

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/28/2024
NAME OF PROVIDER OR SUPPLIER  Aspire at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 2916 Habana Way Tampa, FL 33614	

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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453</b></p> <p>Based on observation, interview, and facility policy review, the facility did not ensure the confidentiality of Protected Health Information (PHI) was maintained for one resident (#395) of 42 residents on the 200 Unit.</p> <p>Findings included:</p> <p>During a facility tour on 06/25/24 at 10:03 a.m. an observation was made of an IV (intravenous) label thrown into a trash can by Resident #395's bed. The IV label included PHI for the resident to include Resident #395's name, name of the medication, prescription number and the medication administration schedule.</p> <p>Review of the Admission Record showed Resident #395 was admitted to the facility on [DATE] with a diagnosis of sepsis.</p> <p>On 06/25/24 at 10:12 a.m. an interview was conducted with Staff F, Registered Nurse (RN). She stated resident's PHI should not be disposed of in the trash. She stated they should maintain the resident's confidentiality and HIPAA (Health Insurance Portability and Accountability Act) per their policy.</p> <p>An interview was conducted on 06/25/24 at 10:28 a.m. with Staff I, Licensed Practical Nurse (LPN). She observed the resident's information inside the trash can. She said, It's his IV information. It should not be in the trash. I believe the nurse who removed it was probably in a hurry. I'll remove the information from the trash can.</p> <p>On 06/25/24 at 10:31 a.m. an observation was made of Staff Q, Certified Nursing Assistant (CNA) removing trash from Resident #395's room. The trash bag was all tied up as she was observed leaving the room. Staff I, LPN stopped her in the hallway and proceeded to retrieve the IV information from the bagged trash. She stated she would dispose of it accordingly.</p> <p>(continued on next page)</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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F 0583  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Review of a facility policy titled, Confidentiality and Privacy, dated 11/30/2014, showed the confidentiality and privacy policy is implemented for the purpose of complying with the privacy/security regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPPA or the Privacy/Security Rule). It is the policy of The Company, LLC to protect the confidentiality of Protected Health Information of its residents. The Procedure showed to never throw sensitive information in the trash. Shredding documents is the only acceptable method of destruction for health or financial information.		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46234</p> <p>Based on observation and interview, the facility failed to provide a safe and homelike environment on three units of three units and one shower room (3rd Floor) out of three shower rooms related to soiled privacy curtains, unpainted/unfinished wall repairs, foul odors, unclean bathroom, disrepair of closets, furniture and light fixture, and a shower chair.</p> <p>Findings included:</p> <p>1. An observation was conducted on 6/25/24 during a facility tour from 10:00 a.m. until 10:35 a.m. of dirty privacy curtains with gray staining in rooms [ROOM NUMBERS], paint/plaster peeling and cracking around the window and air conditioning unit in room [ROOM NUMBER], an unpainted wall repair was observed above the air conditioning unit in room [ROOM NUMBER] and behind the bed in room [ROOM NUMBER]. These items remained in this condition through the end of the survey on 6/28/24. (Photographic Evidence Obtained)</p> <p>Review of a procedure titled, Cleaning Cubicle Curtains, revised 9/5/17, showed the following:</p> <p>Timing &amp; Method</p> <ul style="list-style-type: none"> <li>-Examine curtains while doing QCI (Quality Control Inspection) or at discharge.</li> <li>-If curtain is stained, remove immediately. If curtain is torn-replace.</li> <li>-If curtains are off hooks, repair .</li> </ul> <p>Additional Information</p> <ul style="list-style-type: none"> <li>-Have spare curtains on hand to immediately replace dirty or torn curtains.</li> </ul> <p>46498</p> <p>2. During an observation made on 6/27/24 at 2:00 p.m. Rooms 301, and 307 were observed with stains on the privacy curtains.</p> <p>During an interview on 6/28/24 at 6:24 p.m. the Director of Housekeeping stated his cleaning process is that he deep cleans residents' rooms Monday through Friday. He knows that some residents need new curtains, but he cannot change them out because the facility doesn't have enough curtains. He said he has been aware of the shortage of curtains for five months. He stated he reached out to the Nursing Home Administrator (NHA) to inform her about the facility needing more privacy curtains.</p> <p>50434</p> <p>3. An observation of room [ROOM NUMBER] on 6/25/24 at 10:35 a.m. revealed a wall under the window was bare and unpainted. (Photographic Evidence Obtained)</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on 6/25/24 at 10:45 a.m. of room [ROOM NUMBER]'s bathroom revealed:</p> <p>*A toilet seat with a brown stain,</p> <p>*A brown residue around the bottom of the toilet on the floor, and</p> <p>*Under the sink there was a bare unpainted wall near the pipes of the sink. (Photographic Evidence Obtained)</p> <p>During a tour of room [ROOM NUMBER] and the bathroom on 6/28/24 at 9:00 a.m. the Maintenance Director stated he started with the company in October of 2023 and went through the building and made a list of everything that needed to be completed. He was in the process of getting everything done. He stated the wall had to be patched due to holes. He stated this was not his expectation for a home like environment for residents.</p> <p>37999</p> <p>4. On 6/25/24 at 10:04 a.m. a strong odor of stale urine was noticed in room [ROOM NUMBER]. On 6/25/24 at 10:23 a.m. a very strong urine smell continued in room [ROOM NUMBER].</p> <p>On 6/25/24 at 10:59 a.m. an observation revealed a section of the vinyl cove base was unattached from the bathroom wall in room [ROOM NUMBER] and was lying on the floor. (Photographic Evidence Obtained)</p> <p>On 6/25/24 at 11:26 a.m. an observation revealed in room [ROOM NUMBER] the dresser veneer was torn and the surface underneath was uncleanable.</p> <p>On 6/25/24 at 2:13 p.m. the strong pungent smell of urine continued outside (in the hallway) of room [ROOM NUMBER], which was confirmed by another state agency survey team member.</p> <p>On 6/25/24 at 10:05 a.m. an observation revealed a wire shelf in the closet of room [ROOM NUMBER] had fallen and was lying across the resident's personal items. (Photographic Evidence Obtained)</p> <p>On 6/25/24 at 11:16 a.m. an observation of the third-floor shower room revealed a shower chair with four rusty and uncleanable [NAME] wheels. (Photographic Evidence Obtained)</p> <p>On 6/25/24 at 3:18 p.m. an observation revealed the ceiling light in room [ROOM NUMBER]'s entrance was missing the shade exposing the light bulbs. (Photographic Evidence Obtained)</p> <p>On 6/25/24 at 4:24 p.m. an observation revealed the Packaged Terminal Air Conditioner (PTAC) unit for room [ROOM NUMBER] was plugged into an electrical outlet that did not have a receptacle cover. (Photographic Evidence Obtained)</p> <p>On 6/26/24 at 11:22 a.m. in the hallway outside of room [ROOM NUMBER] there was a strong chlorine-like smell and inside room [ROOM NUMBER] smelled of stale urine.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/26/24 at 3:19 p.m. an observation was made of the closet in room [ROOM NUMBER]. The observation showed the closet did not have closet doors and a wire shelf continued to lie on top of the resident's personal items. (Photographic Evidence Obtained)</p> <p>On 6/28/24 at 9:02 a.m. a tour was conducted with the Director of Maintenance (DOM) of the third floor. The DOM observed the missing ceiling light shade in room [ROOM NUMBER] and stated this should have been reported. The DOM observed the missing receptacle cover in room [ROOM NUMBER] and confirmed it should have been reported. The DOM confirmed the closet wire shelf had been fixed and it had fallen three days ago (6/25/24), parts had to be ordered versus going to a neighborhood store to purchase the parts to rehang the shelf due to the facility not having any petty cash. The DOM stated the rusty shower chair wheels were rusty, uncleanable, and could be replaced. During the tour, an observation revealed the metal sheathing used to cover one side of the ice machine motor was on the floor leaning against the ice bin. The DOM stated this was a safety issue as wires were exposed and the DOM was able to replace the sheathing. The DOM observed room [ROOM NUMBER]'s over-bed table's plastic covering was flaking off and confirmed the odor of urine.</p> <p>An interview was conducted on 6/28/24 at 6:40 p.m. with the Housekeeping Director (HD). The HD reported there were two residents in room [ROOM NUMBER] who would urinate on the floor and the urine has moved under the tile. The HD stated housekeeping cleans the room twice a day and has informed the NHA about two weeks ago.</p> <p>A request was made for a policy regarding providing the residents with a homelike environment, the facility did not provide the policy by the exit of the survey team on 6/28/24.</p> <p>A review of the policy titled, Cleaning and Disinfection of Environmental Surfaces, revised August 2019, showed: Environmental surfaces will be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection of healthcare facilities and the OSHA (Occupational Safety and Health Administration) bloodborne Pathogens Standard. The interpretation and implementation portion of the policy included the following:</p> <p>9. Housekeeping surfaces (e.g. floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled.</p> <p>10. Environmental surfaces will be disinfected (or cleaned) on a regular basis(e.g. daily, three times per week) and when surfaces are visibly soiled.</p>		

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<p>F 0585</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 voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43453</p> <p>Based on interview and record review the facility failed to act upon a resident's grievance for one (#394) resident out of 42 residents on the 200 Unit.</p> <p>Findings included:</p> <p>During a facility tour on [DATE] at 10:13 a.m. Resident #394 was observed in bed. He stated he was constantly hot because the air conditioning (A/C) wall unit in this room did not work. He said, I have provided my own fan. The batteries died . They told my [family member] I can't have a fan that plugs in the wall because there was nowhere to plug it. He stated the family member brought another desk fan and the batteries were dead again. He stated he had notified facility staff. He said, The CNAs [certified nursing assistants] and the nurses know. I have requested a fan if they can't move me. The A/C wall unit was observed to be turned off. The resident stated his roommate turns it off.</p> <p>Review of the Admission Record showed Resident #394 was admitted to the facility on [DATE] with a primary diagnosis of wedge compression fracture of the fourth lumbar vertebra, sequela.</p> <p>Review of the facility's Grievance Log, dated [DATE] to [DATE], showed there was no documented grievance for Resident #394.</p> <p>An interview was conducted on [DATE] at 1:36 p.m. with the Director of Maintenance (DOM). He stated the A/C unit worked, but Resident #394's roommate did not want the AC turned on. He stated he notified the staff of the conflict between the two residents. He said, I don't know if there is anything we can do.</p> <p>On [DATE] at 1:40 p.m. an interview was conducted with Staff I, Licensed Practical Nurse (LPN). She stated she worked in this hall (200) on a regular basis and was familiar with the two residents. She stated Resident #394's roommate did not want the A/C turned on. She said, I know, he turns it off immediately after you turn it on. She stated to the DOM, What are we going to do. Maybe I can speak to the Social Services Director (SSD) for advice. Staff I, LPN confirmed Resident #394's roommate had this problem with every roommate he had.</p> <p>On [DATE] at 3:07 p.m. an interview was conducted with Staff R, Certified Nursing Assistant (CNA). She stated Resident #394's roommate did not like the A/C unit turned on. She stated he turned it off. She stated Resident #394 had been complaining because his roommate would not let him turn on the A/C unit. Staff R said, This morning [Resident #394] said again he was unhappy because it was too hot. She stated a family member brought a fan but there was nowhere to plug it in. Staff R stated the resident had complained to everyone.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with Staff L, LPN/Unit Manager on [DATE] at 3:12 p.m. She confirmed Resident #394's roommate would not let them turn it on. Staff L said, It (the A/C) works. We have spoken to him multiple times. He won't agree. [Resident #394] has requested a room change. I told him I do not have a room right now. Staff L stated she spoke to Admissions regarding roommate compatibility. She stated the owner wanted beds to be filled. She said, I have to wait until we find a place for him.</p> <p>During an interview on [DATE] at 3:32 p.m. Staff S, Assistant SSD stated on [DATE] nursing submitted a grievance related to ADLs (activities of daily living), but not about the room being hot or the request for a room change. She stated their procedure was a resident, family member or staff could initiate a grievance. She stated if the resident notified staff of the room concern, a grievance should be initiated as soon as possible. She stated nursing had not notified the Social Services department. She said, If the roommate did not want the A/C on; then we would initiate a room change.</p> <p>On [DATE] at 4:03 p.m. an interview was conducted with the Director of Nursing (DON). She stated the staff should have initiated a grievance for this resident. She said, Somebody should have documented his concerns. The DON confirmed the expectation was to initiate a grievance to document the resident's concern.</p> <p>On [DATE] at 4:18 p.m. an interview was conducted with the SSD. She stated she had not received any grievances related to this resident's A/C unit or a request for a room change. She stated if the resident had expressed an issue, it should be documented.</p> <p>Review of a facility policy titled, Complaint/Grievance, dated [DATE], showed the intent of this guideline is to support each resident's right to voice grievances and to assure that after receiving a complaint/grievance, the center actively seeks a resolution and keeps the resident appropriately apprised of its progress towards resolution. Prompt efforts by the center to resolve grievances the resident may have, including those with respect to the behavior of other residents. Under Process, the policy showed an employee receiving a complaint/grievance from a resident, family member, and/or visitor shall initiate a complaint/grievance form or electronic equivalent.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46234</p> <p>Based on observations, interviews, and record review, the facility failed to protect the resident's right to be free from neglect for four residents (#47, #114, #124, #126) out of thirty-one sampled residents related to no access to wheelchairs, no assistance getting out of bed, and residents not receiving proper ADL (activities of daily living) care including hair care and dressing.</p> <p>Findings included:</p> <p>1. An interview was conducted on 6/26/24 at 2:17 p.m. with a family member for Resident #114. He said when he brought the resident to this facility, he was looking for a place with more interaction. He said she was only staying in her bed. He said he brought Resident #114's custom wheelchair to the facility for them to use. He said he was told therapy would have to evaluate her before she could use it. He said next, he was told she was not getting up because the chair did not have a seat belt. He said if someone had just lifted the cushion, they would have seen the seatbelt was there. He said when Resident #114 got angry enough she would shake the bed to get staff attention. He said he would like her to get out of bed and have some interaction.</p> <p>Review of Admission Record showed Resident #114 was admitted on [DATE] with diagnoses including aphasia, multiple sclerosis, bipolar disorder, quadriplegia, unspecified intellectual disabilities, anxiety disorder, major depressive disorder, post-traumatic stress disorder, and autistic disorder.</p> <p>Resident #114 was observed to be in her bed with a hospital style gown on throughout the day on 6/25/24, 6/26/24, 6/27/24 and 6/28/24. Her wheelchair was observed in the closet in her room.</p> <p>Review of Resident #114's quarterly MDS, dated [DATE], Section C, Cognitive Patterns, was not able to be completed due to resident rarely/never being understood. Section GG, Functional Abilities and Goals, was not completed due to the questions being disabled.</p> <p>Review of Resident #114's care plan showed a focus area of ADL self-care deficit related to decreased mobility, incontinence, cerebral vascular accident with aphasia, multiple sclerosis, spinal cord injury, and quadriplegia. Interventions included: resident was totally dependent for bathing/showering, dressing, and transfers.</p> <p>2. An interview was conducted on 6/26/24 at 5:10 p.m. with Resident #47. She said she would like to get out of bed, but no one would help her. During a follow-up interview on 6/27/24 at 3:23 p.m., the resident said she had been in her bed for a long time and just wanted to get up. She said she had asked staff multiple times for a wheelchair. Resident #47 said she did not know if she was getting depressed or senile. She said she was surprised she is not in a deep depression from just sitting in her bed all the time. She said her television (T.V. ) was the only thing that saved her. Resident #47 said she would love to get up and be involved in life because she could not last another several years lying in her bed.</p> <p>Review of the Admission Record showed Resident #47 was admitted on [DATE] with diagnoses including non-Hodgkin lymphoma, anxiety disorder, low back pain, and seizures.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #47's care plan showed a focus area of ADL self-care deficit related to limited mobility and musculoskeletal impairment. Interventions included: resident is totally dependent on staff for transferring. Requires assist of 2 staff with mechanical lift.</p> <p>46498</p> <p>3. During an observation on 06/25/24 at 9:30 a.m., Resident # 124 was observed lying down in her bed. She was dressed in her night gown with her call light within her reach. Resident #124 said the staff had not assisted her with her ADLs, they would not get her out of bed. She said she had asked staff to put her on the toilet when she had to have a bowel movement, but she was told to go in her brief. She said she would like to go to activities or even get up out of bed to visit with other residents, but staff would not get her up out of bed. Resident #124 started crying as she was expressing her frustration about the lack of assistance she received from the staff. She said she had told her nurse, but they had not done anything about it.</p> <p>During multiple observations on 6/25/2024 and 6/26/2024 at 11:00 a.m., 1:45 p.m., and 5:00 p.m., Resident # 124 was observed dressed in her night gown, with her call light within reach. She continued to express her frustration about staff not getting her up out of bed.</p> <p>During an interview on 6/27/2024 at 1:45 p.m., Resident #124 was observed lying down in bed, dressed in her nightgown with her call light within reach. Staff E, Registered Nurse (RN)/Weekend Supervisor and Staff J, Licensed Practical Nurse (LPN)/Unit Manager came to Resident #124's room for an observation. Resident #124 stated that she wanted to say something. She began to express to the weekend supervisor and the unit manager about how she had repeatedly asked staff to get her out of bed so she could participate in activities and socialize with other residents. Resident #124 began to cry as she was expressing how she felt about being left in bed all the time. She stated she had not been out of her bed for three months. She said she felt like she was declining due to not being able to get up out of the bed. She stated that she did not want to turn crippled due to her not getting up out of the bed.</p> <p>Review of a Resident Information Record dated 06/28/2024 showed Resident #124 was admitted to the facility on [DATE] with diagnoses to included but not limited to Muscle weakness (generalized), difficulty in walking, not elsewhere classified, other lack of coordination, cerebral palsy, unspecified.</p> <p>Review of a Minimum Data Set (MDS) dated [DATE] showed Resident #124 had a Brief Interview Mental Status (BIMS) score of 14, which indicated she was cognitively intact.</p> <p>Review of a care plan dated 3/29/2024, revealed a care plan focus showing Resident #124 was dependent on staff for meeting emotional, intellectual, physical, and social needs. Review of a care plan goal showed Resident #124 would maintain involvement in cognitive stimulation, social activities as desired through review date. Review of a care plan intervention showed to invite the resident to scheduled activities. Date initiated: 04/10/2023, date revised on 04/10/2024.</p> <p>During an interview on 06/27/24 at 9:33 a.m., with the Advanced Registered Nurse Practitioner, ARNP. The ARNP stated that she was assigned to all the residents at this facility. She said she had spoken with the staff about residents not getting out of their beds. She said the staff told her most of the residents did not have access to wheelchairs so they could not get out of bed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/27/2024 at 2:00 p.m., with Staff E and Staff J, Staff J stated her expectations were that staff assisted their residents with their ADLs and got them out of bed, unless the resident refused to get up. If a resident refused, staff should report it to the nurse so the situation could be documented. She stated it was not acceptable that so many residents were in their beds but some of the residents did not have wheelchairs so they could not get up. She said, her and Social Services were supposed to do an audit to see which resident did not have wheelchairs, but it was not done. She said she was not able to conduct the audits because of her workload with being responsible for the lower part of the 300 hall and the 400 unit located upstairs. She stated everyone in the facility knew they did not have enough wheelchairs to get residents up. Staff E and Staff J stated that they had reported residents did not have enough wheelchairs to get out of the bed to the Director of Nursing and the Nursing Home Administrator during their meetings and nothing had been done about it.</p> <p>During an interview on 6/27/2024 at 2:30 p.m., with Staff G, Certified Nursing Assistant (CNA). She stated that she assisted residents with their ADLs. She only got residents up and dressed them if they asked her to. Some residents could not get out of bed because they did not have wheelchairs.</p> <p>During an interview on 6/27/2024 at 5:30 p.m., with the Nursing Home Administrator. She stated if a resident needed a wheelchair, she or the Director of Nursing could have a wheelchair to the resident by the next day. Her expectations were for all residents to be assessed for what type of chair they needed. She stated she was not aware that there were residents without wheelchairs. She stated she did an audit a couple of times a week on the 4 floors and no one including staff and residents had reported residents not having a wheelchair. She stated had not observed residents dressed in gowns all day. If residents were dressed in gowns all day that would be the preference of the residents. She would expect residents to ask for assistance if they would like to get out of bed or would like to change their clothes. Once the question was clarified she stated her expectation was for the CNAs to ask the resident if they would like to get out of bed or to get dressed.</p> <p>During an interview on 06/28/24 at 11:50 a.m. with the Director of Rehab, he stated when a patient was admitted to the facility Occupational Therapy or Physical Therapy would evaluate the resident for mobility. After the evaluation, it would determine if the resident needed a wheelchair if they were non-weight bearing. When a resident was assigned a wheelchair, they labeled the wheelchair with an ID bracelet to show that the wheelchair was assigned to that resident. Staff have not told the therapy that residents did not have wheelchairs. He said the administrator told him today to start evaluating all the residents to determine their type of mobility. He said he had noticed that there were a lot of residents who remained in their beds and dressed in gowns all day. He said he had mentioned during a Utilization Review (UR) meeting that residents should get out of bed more. He said he explained the risks of residents lying down in bed all the time and how it could cause their skin to breakdown and cause them to have poor circulation. He restated that he was told by the administrator today to re- evaluate all the residents for their wheelchair. He said he did not know what could have happened to the wheelchairs that were assigned to the residents when they were first admitted to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During an Interview on 6/28/2024 at 6:00 p.m., with the Director of Nursing, DON, she stated she had worked at the facility for a year. She stated she was aware that some residents were in bed a lot, but that was because they had refused staff to get them out of the bed. Some residents refused to get up out the bed and some residents did not have wheelchairs. She stated they were aware that residents had not had wheelchairs for a long time, but there was not much they could do about it. They reached out to corporate, and they were denied permission to purchase more wheelchairs. They were told they could only rent about 5 chairs a month. She stated she did not put any interventions in place for those residents who did not have access to wheelchairs.</p> <p>50434</p> <p>4. During an observation and interview on 06/25/2024 at 10:15 a.m. Resident #126 was in bed, dressed for the day. Resident #126's hair was matted and unkept and she stated that she was not able to brush her hair on her own, so she got knots in her hair. Resident #126 stated she really would like to go outside and get some sun, but she was always in bed, which caused her neck and back to hurt. She said she did not ask the CNAs for help because they were short staffed and there was no point.</p> <p>During an interview on 06/27/2024 at 4:50 p.m. Resident #126 was lying in bed crying. Her hair was noted to be visibly unkept and matted and she stated no one had offered to help her out of bed, or to brush her hair. Resident #126 stated, I would just like to go outside for a little while, so I can see something other than these walls.</p> <p>50732</p> <p>37999</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453</b></p> <p>Based on record review and staff interview, the facility failed ensure the Level I Preadmission Screening and Resident Review (PASRR) for residents with a mental disorder and individuals with intellectual disability following qualifying mental health diagnoses were accurate for six residents (#394, #135, #122, #75, #114, and #53), and failed to initiate a Level II PASRR for one resident #53 of 31 residents sampled.</p> <p>Findings included:</p> <p>1. Review of Resident #394's Admission Record revealed an admitted [DATE] with diagnoses to include depression.</p> <p>Review of a Level I PASRR for Resident #394, dated 06/07/24, revealed a blank PASRR and the qualifying diagnoses were not checked.</p> <p>2. Review of Resident #135's Admission Record revealed an admitted [DATE] with diagnoses to include major depressive disorder and seizures.</p> <p>Review of a Level I PASRR for Resident #135, dated 04/06/24, revealed a blank PASRR and the qualifying diagnoses were not checked.</p> <p>46234</p> <p>3. Review of Admission Record showed Resident #114 was admitted on [DATE] with diagnoses to include bipolar disorder, unspecified intellectual disabilities, anxiety disorder, major depressive disorder, post-traumatic stress disorder, and autistic disorder.</p> <p>Review of Resident #114's PASRR Level I Screen, dated 10/17/23, did not show the diagnoses of depressive disorder, autism, or intellectual disabilities. The screening showed it was not a provisional admission and documented, Individual may not be admitted to an [sic] Nursing Facility. Use this form and required documentation to request a Level II PASRR evaluation because there is a diagnosis of or suspicion of (check one of the following): Serious Mental Illness.</p> <p>No PASRR Level II was found in Resident #114's medical record.</p> <p>Review of Resident #114's care plan showed a focus area of PASSR [PASRR]: [Resident #114] is a PASSR [PASRR] level 2. Initiated 10/30/23. Interventions included: Follow up with community partners as needed in regard to PASRR updates and ensure Brief Interview for Mental Status (BIMS) is in place and up to date at each review.</p> <p>An interview was conducted on 6/27/24 at 10:25 a.m. with the Nursing Home Administrator (NHA). She confirmed they did not have a Level II PASRR for Resident #114.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on 6/27/24 at 10:33 a.m. with the Social Services Director (SSD). She said the unit mangers and herself are responsible for the PASRRs once residents are admitted . She said she started working at the facility in August 2023 and did not have access to the PASRR system until 2-3 weeks ago. She said they did an audit and there was a lot of residents from 2018-2019 that need to be fixed and the plan was to fix those. The SSD said they audited residents on the third and fourth floors. She said if the resident was recently admitted or if they are on the second floor they should have a correct PASRR. The SSD reviewed Resident #114's PASRR and confirmed it documented Resident #114 should not be admitted . She said she cannot say why Resident #114 was admitted to the facility. She said the NHA and DON (Director of Nursing) decides who is admitted . The SSD stated she only reviews them after admission.</p> <p>An interview was conducted on 6/27/24 at 11:08 a.m. with the Admission Director. She said she received the PASRR from the hospital and uploaded them into the system. She said once the resident is in the facility, the PASRR is reviewed by the team members trained to look at them to make sure it is correct; it does not get reviewed pre-admission. She said all she does is make sure the facility name is on the PASRR screening form and the date is correct. The Admission Director reviewed Resident #114's PASRR and said she had not been trained on PASRRs and did not know there was a section on the back saying an individual may not be admitted to a nursing facility.</p> <p>An interview was conducted on 6/27/24 at 4:27 p.m. with the DON. She said the facility admissions department is who should review PASRRs for residents prior to admission; to see if a resident needed a Level II completed. She reviewed Resident #114's PASRR and said the Admission Director should have been trained, and she should have called the hospital about the Level II prior to the resident being admitted . The DON confirmed Resident #114 should not have been admitted to the facility based on her PASRR Level I screen.</p> <p>4. Review of Admission Records showed Resident #75 was admitted on [DATE] and readmitted on [DATE] with diagnoses including major depressive disorder, seizures, and bipolar disorder.</p> <p>Review of Resident #75's PASRR Level I Screen, dated 3/24/23, did not include the diagnosis of seizures, which was present on admission, bipolar disorder, which was added on 5/4/23, or major depressive disorder, which was added 8/18/23.</p> <p>The facility was unable to provide an updated PASRR Level I Screen completed after the new diagnoses or prior to re-admission on 5/9/24.</p> <p>50434</p> <p>5. During an interview on 06/25/2024 at 10:45 a.m. Resident #122 stated that she is happy with her care. Resident #122 was observed lying in bed dressed in a hospital gown.</p> <p>Review of Resident #122's Admission Record showed an admitted [DATE] with diagnoses of major depressive disorder, and anxiety.</p> <p>Review of the Level I PASRR, dated 02/23/2024, showed in Section I-Part A MI (Mental Illness) or suspected MI was blank. Part B. ID (Intellectual disability) or suspected ID was blank.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption Not a Provisional Admission was marked no.</p> <p>6. During an observation and interview on 06/25/24 at 10:15 a.m. Resident #53 sated he was really upset with this facility and feels the care is lacking. Resident #53 was observed to be greasy looking with his hair disheveled.</p> <p>Review of Resident #53's Admission Record showed an admitted [DATE] with diagnoses to include major depressive disorder, and schizophrenia.</p> <p>Review of the Level I PASRR, dated 04/12/24, showed in Section I-Part A MI (Mental Illness) or suspected MI (Mental Illness) that schizophrenia was not marked. Part B. ID (Intellectual disability) or suspected ID (Intellectual disability) was blank.</p> <p>Section II: Other Indications for PASRR Screen Decision-Making questions 1 through 7 were marked no.</p> <p>Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption Not a Provisional Admission was marked no.</p> <p>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.</p> <p>37999</p> <p>An interview was conducted on 6/27/24 at 10:33 a.m. with the Social Service Director (SSD). The SSD stated the facility started a Performance Improvement Program (PIP) in early June (2024) regarding the resident's PASRRs. The SSD reported it was the responsibility of the unit managers and social services to review PASRRs, and no one in the facility had access until 2-3 weeks ago (to resubmit the screenings). The SSD reported the facility identified a lot of patients needed changes, some needed Level II evaluations or did not have one in the system.</p> <p>On 6/27/24 at 10:45 a.m. the SSD provided lists that she identified as a full house audit of all resident's PASRR status, which showed if the screenings were correct, action was needed, missing, or a Level II was needed. Review of the list revealed it did not include Residents #394, #135, #122, #75, #114 and #53.</p> <p>On 6/27/24 at 10:53 a.m. the SSD stated the facility did not audit the PASRRs of the residents on the second floor because they were short-term residents, and they would have already gone home. The SSD confirmed that herself and the unit managers review the PASRRs and diagnoses. The SSD stated they check to see if everything is correct and if the resident needs a Level II determination. The SSD stated right now the facility was working on follow up to get PASRRs and the Regional Director had begun working on it, and 2-3 weeks ago they had someone else (working on it). The SSD stated the completion date of the PIP had been 6/20/24. She stated since it had not gotten done the facility decided last week to extend the timeline. The SSD stated PASRRs should be accurate and believed the Regional Director started them two weeks ago.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the policy titled, Preadmission Screening and Resident Review (PASRR), revised 11/8/21, revealed, The center will assure that are Seriously 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 ID receive the care and services they need in the most appropriate setting.</p> <p>1. It is the responsibility of the center to assess and assure that the appropriate pre-admission screenings, either Level 1 or Level 2, are conducted and results obtained prior to admission and placed in the appropriate section of the residence medical record.</p> <p>2. If an individual is declared exempt from a PASRR screening, the center should make sure that the appropriate documentation is on the chart upon admission. Individuals who are exempted from this assessment include:</p> <ul style="list-style-type: none"> <li>- a. Those who are admitted after a release from an acute hospital for a period not to exceed 30 days as part of a medically prescribed period of recovery.</li> <li>-b. Those who are certified by a physician asked to be terminally ill with a 6-month prognosis and are not a danger to self or others.</li> <li>- c. Those who are comatose, ventilator dependent, functions at significantly disabling Parkinson's disease, Huntington's disease, Amyotrophic Lateral Sclerosis, Congestive Heart Failure (CHF), or Chronic Obstructive Pulmonary Disease (COPD).</li> <li>- d. Those with a diagnosis of dementia or its related disorders with detailed documentation supporting this diagnosis.</li> </ul> <p>3. There are no exceptions for Intellectually Disabled (ID) screenings.</p> <p>4. If it is learned after admission that a PASSR Level 2 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.</p> <p>5. Results of the screening evaluation will be placed in the appropriate section of the individual's medical records and any recommendations for services will be followed.</p> <p>6. Recommendations will be incorporated in the individual residents plan of care and approaches/ interventions developed to meet the identified needs of the individual.</p> <p>7. Social services will be responsible for coordinating significant change updates of these screenings, conducted by the appropriate agency. These results, along with the results from the previous years will be kept in appropriate sections of the resident's records.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37999</p> <p>Based on observation, record review, and interview the facility failed to develop and/or implement an effective care plan for three (#57, #75, and #114) out of 53 sampled residents.</p> <p>Findings included:</p> <p>1. On 6/25/24 at 10:44 a.m. Resident #57 was observed with matted hair on the front left side of her head. The resident reported not allowing staff to comb hair because she does it by herself.</p> <p>On 6/28/24 at 11:57 a.m. Resident #57 reported combing her own hair. The observation of the resident showed her hair was matted to the front of her head. At this time, Staff U, Certified Nursing Assistant (CNA) stated the family doesn't want to cut it.</p> <p>Review of Resident #57's Admission Record showed the resident was admitted on [DATE] and readmitted on [DATE]. The record revealed diagnoses not limited to unspecified encephalopathy, mood disorder due to known physiological condition with mixed features, and dementia in other diseases classified elsewhere severe without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>Review of Resident #57's June 2024 Medication Administration Record (MAR) showed the staff documented the resident was combative 6 out of 54 shifts and did not have any other behaviors.</p> <p>Review of Resident #57's care plan revealed the following:</p> <ul style="list-style-type: none"> <li>- Has an Activities of Daily Living (ADL) self-care performance deficit r/t (related to) decreased mobility, morbid obesity, Diabetes Mellitus (DM), hx (history) of falls, (and) right leg pain. The interventions revealed the resident required supervision for personal hygiene.</li> <li>- Has behaviors r/t refusal of personal care from males, refusal of UA C&amp;S (Urinalysis Culture &amp; Sensitivity), non-compliant with skin sweeps, she speaks not so nice to staff who enter her room, tells staff she doesn't like them or to get out of her room, fabricates stories, 2 staff to go into room when providing care, refusal of meds, refusal to go to ER (emergency room ), refusal to be straight cathed, yelling at staff, refusal of incontinence care, (and) refusal of med (medication) neb (nebulizer) treatments.</li> </ul> <p>During an interview on 6/28/24 at 5:14 p.m. the Director of Nursing (DON) stated Resident #57 does refuse staff to comb her hair and the facility has asked the spouse to cut her hair, which is refused.</p> <p>Review of the care plan for Resident #57 did not reveal the facility had developed a care plan or interventions related to the resident's matted hair and the resident/family refusal to assist with the resident's hair.</p> <p>46234</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. An interview was conducted on 6/25/24 at 10:18 a.m. with Resident #75. He said he received glasses, but they do not work. He said he cannot see very well, can't read menus, and people are just shadows.</p> <p>Review of the Admission Record showed Resident #75 was admitted on [DATE] with diagnoses including malignant neoplasm of the brain, hemiplegia and hemiparesis following cerebral infarction, and chronic migraine.</p> <p>Review of Resident #75's Annual Minimum Data Set (MDS), dated [DATE], Section C - Cognitive Patterns, showed he had a BIMS score of 13, indicating he is cognitively intact. Section B - Hearing, Speech, and Vision showed he had highly impaired vision.</p> <p>Review of Resident #75's care plan did not show any focus areas or interventions related to vision loss.</p> <p>An interview was conducted on 6/28/24 at 9:47 a.m. with Staff FF, Certified Nursing Assistant (CNA). She said she frequently cares for Resident #75. She said he can see about 50% of things and can see if they are close to him. She said she sometimes reads his mail to him when he asks for help. Staff FF said sometimes activities brings the resident crossword puzzles, but he can't see to do them.</p> <p>An interview was conducted on 6/28/24 at 9:57 a.m. with Staff EE, Licensed Practical Nurse (LPN). She said Resident #75 had vision issues and wears glasses, but she doesn't know how much he can see. She said sometimes he will ask staff to read things to him and will ask for the room light to be off so he can try to see the TV better.</p> <p>An interview was conducted on 6/28/24 at 10:17 a.m. with the MDS Coordinator. She said normally when the MDS is done for a resident, the care plan is revised by the person doing the MDS. She said the care plan is updated with current information from the new assessment. She said she does not know Resident #75, but if someone had vision issues the system would trigger to do a care plan. She reviewed Resident #75's Annual MDS and confirmed it noted highly impaired vision. She confirmed he had no care plan in place and said his needs are not being accommodated if he can't read or see things.</p> <p>3. Review of the Admission Record showed Resident #114 was admitted on [DATE] with diagnoses to include bipolar disorder, unspecified intellectual disabilities, anxiety disorder, major depressive disorder, post-traumatic stress disorder (PTSD), and autistic disorder.</p> <p>Review of Resident #114's care plan did not show any focus area or interventions in place related to autistic disorder.</p> <p>An interview was conducted on 6/28/24 at 10:17 a.m. with the MDS Coordinator. She said she had only been in the facility a couple of months and did not know all the residents, including Resident #114. She reviewed Resident #114's diagnoses and care plan. She stated that every diagnosis does not require a care plan, but anything that would be psychological and/or effect behavior should have one. She said autism effects everything and should be care planned.</p> <p>Review of a facility policy titled Plans of Care, revised 9/25/17, showed the following:</p> <p>Policy:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements.</p> <p>Plan of care is to be maintained as part of the final medical record.</p> <p>Procedure:</p> <ul style="list-style-type: none"> <li>-Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment .</li> <li>-The Individualized Person-Centered plan of care may include but is not limited to the following: <ul style="list-style-type: none"> <li>. Resident's strengths and weaknesses.</li> <li>. Services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required by state and federal regulatory requirements.</li> <li>. Other state and federal services, which are not being provided due to respecting a resident's right to refuse care.</li> <li>. Resident's goals for admission and desired outcomes, as well as preferences and potential for future discharge.</li> <li>. Individualized interventions that honor the resident's preferences and promote achievement of the resident's goals.</li> <li>. Interdisciplinary approaches that maintain and/or build upon resident abilities, strengths, and desired outcomes.</li> <li>. Alternative treatments as applicable.</li> </ul> </li> </ul>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46498</p> <p>Based on observation, record review and interview the facility failed to implement an effective discharge planning process to assist one resident (#72) with a discharge to another facility out of eight residents sampled.</p> <p>Findings included:</p> <p>During an observation made on 06/25/24 at 9:30 a.m., Resident #72 was observed lying down in bed dressed in her night clothes. Resident #72 was not able to verbally answer interview questions. She pulled out her phone to write her responses down. She wrote the staff at the facility was not treating her good. Staff will not assist her with her ADLs (activities of daily living). She said she was supposed to be up right now for her therapy, but she was not able to go because the aide from the 11:00 p.m. to 7:00 a.m. shift did not get her up. She said her and her [family member] requested that she be transferred to another facility but the person in social services will not assist them.</p> <p>Review of the Admission Record showed Resident #72 was admitted originally on 2/16/24 and readmitted on [DATE] with diagnoses to include acute embolism and thrombosis of left femoral vein, bipolar II disorder, major depressive disorder recurrent, unspecified, anxiety, adjustment disorder with mixed anxiety and depressed mood.</p> <p>Review of a Minimum Data Set (MDS), dated [DATE]. Section C - Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #72 was cognitively intact.</p> <p>Review of a care plan, initiated 2/20/24, showed a focus of: [Resident #72] wished to return/be discharged home. Review of the care plan goal showed [Resident #72] will verbalize/communicate an understanding of the discharge plan and describe the desired outcome by the review date. The interventions showed: established a pre-discharge plan with the resident/resident's representative/ caregivers and evaluate progress and revise plan; make arrangements with required community resources to support independence post-discharge homes [sic], PT (physical therapy), OT (occupational therapy), MD (medical doctor), wound nurse.</p> <p>During an interview on 6/26/24 at 2:00 pm. with Resident #72's family member, she stated she spoke with the Social Services Director (SSD) at the facility to see if they could assist them with trying to move [Resident #72] to another facility. She said the SSD told her that another facility will not take [Resident #72] at this time because she is Medicaid pending. She said [Resident #72] has been Medicaid pending since March.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Aspire at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE  2916 Habana Way Tampa, FL 33614	
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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/27/24 at 5:00 pm. with the SSD, she stated when a resident wants to transfer to another facility, she would help them by providing a list of facilities they could choose from. Sometimes the resident or their representatives may have a facility that they have already selected. Then she would reach out to the facility of their choice to coordinate the discharge between the resident and the facility. Some facilities may not take residents based on their payor source, for example if a resident is Medicaid pending then some facilities may not want to take the resident until their Medicaid is fully processed. She said the resident and her family member came to her to tell her that the resident wanted to go home but then they changed their mind and wanted her to transfer to another facility. [Resident #72's family member] reached out to her about wanting [Resident #72] to be transferred to another facility. I told her that [Resident #72] is Medicaid pending and most facilities will not take her until her Medicaid has been processed. The SSD said she did not assist the resident with looking for another facility because she knows, based on her own experience, that another facility would not take the resident because she is Medicaid pending.</p> <p>An interview was conducted with the Business Office Manager (BOM) following the interview with the SSD. The BOM stated the facility has a Medicaid specialist who does the Medicaid applications. The BOM stated On 6/18/2024 they reviewed Resident #72's file and saw the resident's application was not pulled from the system, meaning no one has pulled her application to work on it.</p> <p>The facility did not provide a policy related to discharge planning by the last day of the survey on 6/28/24.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43453</p> <p>Based on observation, interview and record review the facility did not ensure a functional communication system implemented for two (#393 and #97) of three residents sampled.</p> <p>Findings included:</p> <p>1. On 06/25/24 at 10:19 a.m., and on 06/25/24 at 12:47 p.m. observations were made of Resident #393 laying on her bed. The resident did not respond to the interview attempts. During the observations, it was noted there were no alternate communication tools to enable this resident to interact with anyone.</p> <p>On 06/25/24 at 1:02 p.m. an interview was conducted with Staff I, Licensed Practical Nurse (LPN). She stated this resident was non-verbal following a stroke. She stated she observes her body to know what she needed. She stated it was hard to know what she really needed.</p> <p>Review of the Admission Record showed Resident #393 was admitted to the facility on [DATE] with diagnoses of traumatic hemorrhage of cerebrum, unspecified without loss of consciousness, subsequent encounter, acute respiratory failure, aphasia, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side.</p> <p>Review of a document titled, Baseline Care Plan and Summary, showed Resident #393 will be able to communicate desires/needs. The section titled Other, was noted blank.</p> <p>On 06/26/24 at 2:30 p.m. an interview was conducted with Staff R, Certified Nursing Assistant (CNA). She stated she does not speak with the resident. She said, The resident cannot speak. I go in and take care of her . I let the nurse know if I don't know what is going on.</p> <p>On 06/28/24 at 11:50 a.m. an interview was conducted with Staff L, LPN/Unit Manager. She stated this resident was non-verbal. She communicates through text messaging. She stated the resident could squeeze your hand to answer to yes and no questions.</p> <p>On 06/28/24 at 11:58 a.m. an interview was conducted with Staff Q, CNA and Staff Z, CNA. They stated they communicate with this resident by observing her face to see if she was happy or if she was sad. They confirmed they did not know this resident's preferred method of communication.</p> <p>On 06/28/24 at 12:31 p.m. an interview was conducted with the Director of the Nursing (DON). She stated if a resident was non-verbal, there should be a communication board in their room. She stated the resident was able to text using her phone. She stated the Unit Manager should share the unit cell phone with Resident #393 so she can communicate with them. She stated this should be documented in the care plan so all staff know how the resident communicated. The DON stated in the resident's care plan under the section Other, the MDS (Minimum Data Set) nurse should have entered alternate measures; such as use of a cell phone or a communication board. She stated all staff should be informed on how to interact with this resident.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/28/24 at 1:00 p.m., an interview was conducted with the MDS Coordinator/Registered Nurse (RN). She stated Resident #393 communicated via text message. She stated she had not spoken to the resident, but she created the baseline care plan after reviewing her admission paperwork. She said, Regarding the care plan, it should say the resident was non-verbal and include this resident's appropriate communication style. The MDS Coordinator/RN confirmed the baseline care plan showed the resident's non-verbal status was not identified.</p> <p>An interview was conducted with Staff AA, Speech Therapist (ST) on 06/28/24 at 2:01 p.m. She stated Resident #393 was non-verbal and they were working on hand squeezes. She stated the resident nodded yes and no, responded to eyebrow raises, blinking and visual picture boards. She stated they were working on pointing. Staff AA stated the most effective method of communication was to use her left hand and left eyebrow. Staff AA, ST stated they should have put this information in a place where everyone knew how to interact with Resident #393. She confirmed the care plan should be updated to include the appropriate communication methods.</p> <p>Review of a facility policy titled, Plans of Care, dated 11/30/14, showed an individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and or resident representative to the extent practicable and updated in accordance with state and federal regulatory requirements. Under procedure the policy showed to develop and implement an individualized person-centered baseline plan of care within 48 hours of admission that includes but not limited to initial goals on the admission orders physician orders ., if applicable the other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs are met appropriately until the comprehensive plan of care is completed.</p> <p>46498</p> <p>2. During an observation made on 06/26/24 at 9:22 a.m. Resident #97 was observed lying down in bed dressed in her night clothes. She was not able to verbally communicate. She was observed pointing at different things and hitting on herself trying to communicate.</p> <p>During an observation made on 06/26/24 at 3:00 p.m. Resident #97 was observed lying down in bed dressed in a night gown. The resident was not able to communicate her needs. Resident #97 was observed trying to express herself with moving her hands around.</p> <p>Review of the Admission Record showed Resident #97 was admitted to the facility on [DATE] with diagnoses to included but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and depression unspecified.</p> <p>Review of Resident #97's medical record showed she did not have a communication care plan in place to assist her with her communication needs.</p> <p>During an interview on 06/27/24 at 6:00 p.m. Staff Y, CNA stated he can communicate with Resident #97. He stated when he enters her room, he calls her mom and asks her what she wants. Staff Y called out mom to Resident #97 and he was not able to understand what Resident #97 was trying to tell him. He stated she has a board that she can write on if she wanted to tell him something.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/28/24 at 9:55 a.m. the MDS Coordinator/RN stated care plans are created by the information triggered from the MDS. For a resident that is nonverbal, Section B on the MDS for hearing communication would be checked as rarely or never understood. This would then trigger for a communication care plan to be created. Resident #97's care plan was done in April (2024). She was coded as usually understood, which may have been coded wrong. She stated she was not here at the facility when the resident care plan was done. This was her first time even seeing the resident. No one told her about this resident's communication needs. She stated what she can see is that Resident #97 should have a communication care plan in place. She stated she will get therapy to see what she can do as far as getting the resident assessed and she will create a communication care plan with the appropriate intervention for the resident. The Director of MDS asked Resident #97 if she can write on the board that is next to her. Resident #97 was not able to write on the board that was given to 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50434</p> <p>Based on observation, record review and interview the facility did not ensure activities of daily living (ADLs) were completed and maintained for two (#126 and #97) out of two residents sampled.</p> <p>Findings included:</p> <p>1. During an observation and interview on 06/25/2024 at 10:15 a.m. Resident #126 was in bed, dressed for the day. Resident #126's hair was matted and unkept, she stated that she is not able to brush her hair on her own, so she gets knots in her hair. Resident #126 stated she really would like to go outside and get some sun, but she is always in bed, which causes her neck and back to hurt. She stated she does not ask the CNAs (certified nursing assistants) for help because they are short staffed and there is no point.</p> <p>During an interview on 06/27/2024 at 4:50 p.m. Resident #126 was lying in bed crying, and her hair was noted to be visibly unkept and matted. She stated no one has offered to help her out of bed, or to brush her hair. Resident #126 stated, I would just like to go outside for a little while, so I can see something other than these walls.</p> <p>Review of Resident #126's Admission Record revealed she was admitted to the facility on [DATE] with medical diagnoses of pain in left shoulder, muscle wasting and atrophy, weakness, unspecified abnormalities of gait and mobility, and unsteadiness on feet.</p> <p>Review of Resident #126's Quarterly Minimum Data Set (MDS), dated [DATE], Section C - Cognitive Patterns revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Shows resident cognitive level is intact. Functional Abilities and Goals, Section GG revealed Resident #126 has an impairment to her upper and lower extremity on one side and requires substantial/maximal assistance for Toileting hygiene, and Shower/bathe care, upper body dressing, lower body dressing, and putting on/taking off footwear. Resident #126 requires Partial/Moderate assistance for personal hygiene. According to the Self-Care Coding Substantial/maximal means the helper does more than half the effort. The helper lifts or holds trunk or limbs and provides more than half the effort and Partial/Moderate assistance means helper does less than half the effort. A helper lifts or holds trunk or limbs and provides less than half the effort.</p> <p>During an interview on 06/28/2024 at 5:00 p.m. Staff BB, CAN stated she needed a translator to answer questions and at this time another CNA on the floor translated for her. She stated she was not familiar with Resident #126 since this was the first time she has worked with her. She stated she typically provides residents with showers, diaper changes, and provides water and ice. She stated she had not offered to help Resident #126 to brush her hair or to get out of bed since being assigned to her.</p> <p>During an interview on 06/28/2024 at 5:00 p.m. Staff CC, CNA stated he is typically assigned to the other end of the hall and was not familiar with Resident #126's care. He stated part of his job as a CNA is to help residents with showers, diaper changes and provide them with water and ice. He stated he has not offered Resident #126 help with getting out of bed because it is too difficult for him to do.</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 06/28/2024 at 8:55 a.m. Staff L, Licensed Practical Nurse/Unit Manager (LPN/UM) stated Resident #126 can be confused at times. She stated that she has a lot of new CNAs and she has to remind them they should be offering personal hygiene care to include brushing hair and shaving the residents. She stated she used to get a lot of care concerns with her 3:00 p.m. to 11:00 p.m. shift nurses, but it has really turned around. She stated she noticed residents, who do not speak Spanish, are not getting as good of care as residents who do speak Spanish.</p> <p>46498</p> <p>2. During an observation made on 06/26/24 at 9:22 a.m. Resident #97 was observed lying down in bed dressed in her night clothes. She was not able to verbally communicate. She was observed pointing at different things and hitting on herself trying to communicate.</p> <p>During an observation made on 06/26/2024 at 3:00 p.m Resident #97 was observed lying down in bed dressed in the same night gown all day. The resident was not able to communicate her needs. Resident #97 was observed trying to express herself with moving her hands around.</p> <p>Observations were made multiple times during the survey on 06/26/2024, 06/27/2024, and 6/28/2024 during multiple times and revealed Resident #97 in bed dressed in her night gown all day and evening.</p> <p>Review of a Admission Record showed Resident #97 was admitted to the facility on [DATE] with diagnoses to included but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, diabetes mellitus due to underlying condition with diabetic autonomic (Poly) neuropathy, depression unspecified, and other lack of coordination.</p> <p>Review of a Quarterly Minimum Data Set (MDS), dated [DATE], showed a Brief Interview for Mental Status, (BIMS) score of 03, which indicated Resident #97 is severely cognitively impaired.</p> <p>Reivew of a care plan, dated 4/17/2024, showed a care plan Focus of Resident #97 has an ADL self- care performance deficit related to decreased mobility, cerebral vascular accident with hemiparesis/aphasia, liver injury, chronic obstructive pulmonary disease, hypertension, Diabetes Mellitus, paroxysmal atrial fibrillation. Date initiated 10/30/2023 and revised on 10/30/2023. Review of the care plan goal showed Resident #97 will improve current level of function in through the review date. Review of the care plan interventions showed Resident #97 requires substantial assist for upper body dressing and dependent for lower body dressing. Further review of the care plan interventions showed the resident requires substantial assist x1 for bathing/ showering. Date initiated 10/30/2023 and revised on 11/06/23.</p> <p>During an interview on 6/27/24 at 2:00 pm. Staff H, Certified Nursing Assistant (CNA) stated some residents are still in bed dressed in their gowns because they have not requested to get up out of bed. She said if her residents ask her to get up then she will assist them.</p> <p>During an interview on 6/27/24 at 2:30 p.m. with Staff J, License Practical Nurse/Unit Manager (LPN/UM) she stated her expectations are that staff dress and get their residents up out of bed. If residents refuse care, then the aides should make sure they report it to their nurse, so that we can address the situation.</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 6/28/24 at 6:00 p.m. the Director of Nursing (DON) stated that her expectation is that staff assist their residents with ADL care. She said she was told by her staff that residents are in their beds and dressed in gowns because the residents refused staff assistance. She stated some residents don't have wheelchairs to get up in, but staff should assist with their care, dressing and get them up if they can.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37999</p> <p>Based on observation, record review, and interview the facility failed to provide life-enriching activities for three residents (#79, #57, and #124) out of 53 sampled residents.</p> <p>Findings included:</p> <p>1. Review of the posted Community Life Calendar posted outside of the main dining room, in the unit dining rooms revealed the following scheduled activities:</p> <p>6/25/24: 10 a.m. - Room Visits, 12 p.m. - Taco Tuesday, and 2 p.m. - Ice Cream Social.</p> <p>6/26/24: 10 a.m. - Trivia with [NAME], 12 p.m. - Room Visits, and 2 p.m. - Bingo.</p> <p>6/27/24: 10 a.m. - Coffee, Tea, and Me, 12 p.m. - Outdoor Social, and 2 p.m. - Lemonade Stand.</p> <p>6/28/24: 10 a.m. - Sip &amp; Paint, 12 p.m. - Fish Fry and June Birthday Party, and 2 p.m. - Resident Council Follow Up.</p> <p>Review of Resident #79's Admission Record revealed the resident was admitted on [DATE], 10/18/21, and readmitted on [DATE]. The Admission Record included diagnoses not limited to unspecified low back pain, unspecified recurrent major depressive disorder, unspecified anxiety disorder, and unspecified psychosis not due to a substance or known physiological condition.</p> <p>During an interview on 6/25/24 at 10:48 a.m. Resident #79 stated nobody reads the activity calendar to her. During a review of the activity calendar, which was posted on the wall behind and to the side of the resident, it was noted the upcoming activity of an Ice Cream Social. Resident #79 reported liking ice cream and would get up if she had a wheelchair.</p> <p>On 6/26/24 at 3:58 p.m. Resident #79 was observed lying in bed with the television on the dresser next to her bed and a television remote in front of the television. The remote was not within reach of the resident who was lying flat in bed. Staff W, Registered Nurse (RN) arrived in the room stating she had come to answer Resident #79's call light (the resident's call light was on). Staff W stated Resident #79 asked to get up and go smoke but the resident didn't smoke. The resident asked if Staff W could get her a wheelchair.</p> <p>An interview on 6/26/24 at 4:01 p.m. was conducted with Staff W, RN. Staff W reported working with Resident #79 three days a week and was not sure if the resident had a wheelchair. Staff W did not think the resident had ever gotten out of bed.</p> <p>Review of Resident #79's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 7 out of 15, indicating a severe cognitive impairment. The MDS showed the resident required substantial/maximal assist with bed mobility and transfers.</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 - Some</p>	<p>Review of Resident #79's Comprehensive MDS, dated [DATE], showed the resident was interviewed regarding Activity Preferences. The resident voiced keeping up with the news and doing favorite activities were Somewhat important.</p> <p>Review of Resident #79's Community Life Progress Review, dated 1/2/24, showed the resident was content with their activity pursuits, individual/independent activities participation were as needed/wanted. The assessment revealed the resident had the needed supplies to pursue their interests, participated in small and large group activities and outside the center events as needed/wanted. The resident's physical reaction during programming and emotion expressed was Smiling and laughing with the other residents, expresses happiness. The resident has made friends in the facility, did not have any new hobbies or changes to likes or dislikes, no interests/talents that the resident can share, does not actively participate in Resident Council, or have any interest in forming a club.</p> <p>Review of Resident #79's care plan showed the resident was independent of staff for meeting emotional, intellectual, physical, and social needs, revised on 11/17/21. The goals of this focus were the resident would maintain involvement in cognitive stimulation, and social activities as desired through review date, revised on 10/25/23 and a target date of 7/9/24. The interventions included:</p> <ul style="list-style-type: none"> <li>- Introduce the resident to residents with similar background, interests, and encourage/facilitate interaction.</li> <li>- Invite the resident to scheduled activities.</li> <li>- Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression, and responsibility.</li> <li>- Provide with a Community Life calendar. Notify resident of any changes to the calendar of activities.</li> </ul> <p>During an interview with the Activities Coordinator (AC) on 6/28/24 at 10:44 a.m., the AC reported being independent (with activities) meant they did not need staff to assist with social needs. The AC stated she would not consider Resident #79 as independent and reported going to the resident's room to talk, and the resident does not get out of bed. She stated Resident #79 doesn't have a wheelchair; it disappeared. The AC reported seeing Resident #79 twice yesterday (6/27/24) because the call light was on and had to speak to the resident because she was yelling. The AC reported not documenting 1:1 visits but did visit with the resident. The resident has a television and can verbalize what channel she wants to watch. The AC stated the resident liked to socialize with other residents. She stated, been over a month since (the resident) has been out of bed, previously the resident would come down and socialize.</p> <p>A continued interview was conducted on 6/28/24 at 11:39 a.m. with the Activity Coordinator. The AC stated, for an ice cream social she would go floor to floor with a cart and offer it to people who can have a few scoops in a bowl. The AC reported offering ice cream on Resident #79's floor at 10:30 a.m. on 6/25/24.</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 - Some</p>	<p>2. An observation and interview was conducted with Resident #57 on 6/25/24 at 10:40 a.m. The resident reported not knowing about any activities and would go if asked; depending on the activity. The observation did not show the resident had a viewable activity calendar. The observation revealed the television for the resident was on a bedside dresser at the resident's head of bed, which was behind the resident when the head of bed was elevated. The television was not turned on.</p> <p>Review of Resident #57's Admission Record revealed an admitted [DATE] and re-admission on 11/15/23. The Admission Record included diagnoses not limited to unspecified recurrent major depressive disorder, dementia in other disease classified elsewhere severe without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and mood disorder due to known physiological condition with mixed features.</p> <p>Review of Resident #57's Comprehensive Minimum Data Set (MDS), dated [DATE], showed the resident was interviewed regarding daily and activity preferences. The interview showed being around animals and doing favorite activities were very important and doing things with groups of people and going outside for fresh air was somewhat important.</p> <p>Review of Resident #57's Community Life Progress Review, dated 4/5/24, revealed Resident #57 was content and happy about activity pursuits. The resident participated in individual/independent, small group, large group, and outside the center events as needed/wanted. The review showed the resident required minimal assistance to complete activities. The resident's reaction to programming was Smiling and laughing during programming, expresses happiness. The resident had made friends in the center, did not have any new hobbies or changes in likes/dislikes, did not have any interests or talents to share with other residents, and was not interested in forming a club.</p> <p>Review of Resident #57's Quarterly MDS assessment, dated 4/22/24, revealed a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating severe cognitive impairment. The assessment showed the resident did not utilize any mobility device at admission or currently and required substantial/maximal assistance with chair/bed-to-chair transfers.</p> <p>Review of Resident #57's care plan revealed the following:</p> <ul style="list-style-type: none"> <li>- Resident has little or no Community Life involvement r/t poor adjustment to the facility/unit, resident wishes not to participate, initiated 7/26/23. The interventions instruct staff to explain to the resident the importance of social interaction, leisure activity time and encourage the resident's participation with daily room visits), revised 11/6/23, remind the resident that the resident may leave activities at any time and is not required to stay for the entire activity. Additional interventions included the resident needs assistance/escort to Community Life functions and to invite/encourage the resident's family members to attend activities with resident in order to support participation.</li> </ul> <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 - Some</p>	<p>An interview was conducted with the Activity Coordinator (AC) on 6/28/24 at 11:08 a.m. The AC reported she considered Resident #57 was independent for emotional and social needs but dependent with Activities of Daily Living (ADLs). She stated the resident's participation depended on the resident's mood, and she has not seen the resident out of bed and does not provide the resident with any activity. The AC stated a calendar is provided to the resident. She stated depending on the corkboard location she does not know if the resident would be able to read it. She reported there was an activity cart in the dining room of each unit containing crayons, crosswords, and magazines, I will pass out if they ask. She stated the resident does not have a wheelchair to get out of bed.</p> <p>During the continued interview on 6/28/24 at 11:08 a.m. the AC explained that Taco Tuesday on 6/25 was scheduled for noon. She reported buying taco supplies for the independent residents and taking the supplies to the floor, but it did not occur because the facility did not have any petty cash. The AC reported she was supposed to pick up the birthday cake at 9:00 a.m. for the activity of fish fry and birthday party, scheduled for noon on 6/28, but had to participate in the survey. She wasn't able to pick up the cake, and no one else was able to pick up the cake because she had to pay for it out of her pocket. The AC stated she understood about quality of life. The AC stated, All of Us have discussed that the resident's don't have wheelchairs or Geri chairs to get out of bed, and was expected to do a job but didn't have the stuff to do the job. The AC reported not knowing why the activity, Trivia with [NAME], scheduled for 10 a.m. on 6/26 had not occurred. The AC reported she did not document 1:1 room visits, had been coordinator for a year and had received very little training for the job. The AC reported not knowing what time the fish fry on 6/28 was scheduled for and it was not part of the resident's lunch (menu: cornflake-crusting tilapia filet). In regard to the activity of popcorn and movie that had been scheduled for noon on Sunday 6/23, she stated she didn't think popcorn and a movie at noon interfered with nutrition (the noon meal).</p> <p>Review of the Community Life calendar revealed an activity was scheduled at noon every day and no activity started later than 2:30 p.m. (church service on Saturday 6/29).</p> <p>Review of the facility mealtimes showed lunch in the main dining room was served at 12:15 p.m. and residents on the third floor did not receive lunch trays till 1:30 p.m. and 1:45 p.m.</p> <p>46498</p> <p>3. During an observation on 6/25/24 at 9:30 a.m. Resident #124 was observed lying down in her bed. She was dressed in her night gown. She said she would like to go to activities or even get up out of bed to visit with other residents, but staff will not get her up out of bed.</p> <p>Review of a Admission Record showed Resident #124 was admitted to the facility on [DATE] with diagnoses to include to muscle weakness (generalized), difficulty in walking, not elsewhere classified, other lack of coordination, cerebral palsy, unspecified.</p> <p>Review of a Minimum Data Set (MDS), dated [DATE], showed Resident #124 had a BIMS score of 14, which indicated she is cognitively intact.</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 - Some</p>	<p>Review of a care plan, dated 3/29/24, showed a care plan Focus of Resident #124 is dependent on staff for meeting emotional, intellectual, physical, and social needs. The Goal showed Resident #124 will maintain involvement in cognitive stimulation, social activities as desired through review date. The interventions included to invite the resident to scheduled activities. Date initiated: 04/10/23, date revised on 04/10/24.</p> <p>During an interview on 06/28/24 at 1:30 p.m. the Activities Coordinator stated that she is responsible for the unit Resident #124 resides on. She stated last week when she went to Resident #124's room; the resident told her that she would like to get up out of bed so that she could socialize with other residents, and she wanted to get her hair done. She said she did not do any activities with the resident. She stated she just went to her room to deliver a meal tray. She stated she did not report to anyone that Resident # 124 wanted to get up for activities. She said Resident #124 has not been out of bed for a while.</p> <p>Review of the facility policy titled, Social Activities, effective date 11/30/24, showed: Policy: The Social Activities are modified to meet the basic needs of love and belonging in residents who experience deficits in judgment, reasoning and perception. The activities focus on acceptance of the individual and the stimulation of learned social responses.</p> <p>Purpose: To provide opportunities for socialization regardless of one's cognitive limitations. To provide an atmosphere of acceptance through strategic grouping of residents. To encourage the development of friendships.</p> <p>Procedure: 1. Social Activities shall be offered 3-4 times per day.</p> <p>Review of the facility policy titled, Individual Activities, effective date 11/01/21, showed: Residents who are unwilling and/or unable to attend scheduled group activities are provided with one-to-one individual recreational and Community Life based on their needs, interests and functional ability.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43453</p> <p>Based on observation, interview and record review, the facility did not ensure residents with limited mobility received restorative services to maintain or improve mobility and/or range of motion (ROM) for three (#129, #31 and #102) of four residents reviewed.</p> <p>Findings included:</p> <p>1. On 06/25/24 at 10:33 a.m. Resident #129 was observed in his room sitting on his bed. The resident said, I came off from rehab, they said I'm cut off. I'm not on any restorative services. The resident stated he was trying to keep the exercises going by himself. He stated he did not want to lose the momentum. He stated he wished he could receive some kind of therapy.</p> <p>Review of the Admission Record showed Resident #129 was admitted to the facility on [DATE] with diagnoses to include difficulty in walking and encounter for orthopedic aftercare.</p> <p>Review of a document titled, Therapy Communication to Restorative Nursing Program showed on 06/04/24 Resident #129 was assessed for the facility's restorative program for bed mobility. The Problems/Needs section showed to maintain BLE (Bilateral Lower Extremities) strength/endurance and joint flexibility. The Recommendations showed AROM (Active ROM) to BLE 3X15 reps and ambulation 100-200 with 2WW (2 wheeled walker). Perform 3 times a week for 6 weeks.</p> <p>2. Review of the Admission Record showed Resident #31 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a primary diagnosis of polyneuropathy.</p> <p>Review of a document titled, Therapy Communication to Restorative Nursing Program, showed on 06/20/24 Resident #31 was assessed for the facility's restorative program for feeding, upper body dressing, lower body dressing, shoes and CGA (Contact Guard Assistance) for toilet transfers (SGA). The Problems/Needs section showed Resident #31 was legally blind. The recommendations showed to 1. Raise arms towards the ceiling. 2. Raise arms out to the side, 3. Bend and strengthen elbows and 4. Make a fist and strengthen fingers for 3 times a week for 6 weeks.</p> <p>3. Review of the Admission Record showed Resident #102 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include chronic pain syndrome.</p> <p>Review of a document titled, Therapy Communication to Restorative Nursing Program, showed on 05/27/24 Resident #102 was assessed for the facility's restorative program for moderate assistance for transfers and assistance for bed mobility. The section Problems/Needs showed to maintain functional mobility tissue flexibility and strength. The Recommendations showed to perform Active ROM to BLE in all joints available 2X15. Perform 3 times a week for 6 weeks.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/27/24 at 1:02 p.m. an interview was conducted with Staff T, Certified Nursing Assistant (CNA)/ Restorative Aide. She stated she provided restorative therapy to the residents assigned to her. She stated she was familiar with all the residents on her case load but not Resident #129. She said, He is not on my assignment. If he was, I would be seeing him per therapy orders. Staff T shared her restorative Tracking Form for review. It did not include Residents #129, #31, and #102.</p> <p>On 06/27/24 at 1:09 p.m. a follow-up interview was conducted with the Director of Rehabilitation (DOR). He stated he previously worked with Resident #129. He said the resident was no longer on case load because he had reached his maximum potential. He stated he had transitioned him to restorative therapy and put in orders. He stated nursing may have dropped the ball. The DOR said, It is a very simple thing. Nursing did not communicate after the previous ADON [Assistant Director of Nursing] left. We did our part on our end. It should not have taken this long to execute the program. The residents should have transitioned to the restorative program right away. The DOR stated the transition should happen within a couple days to ensure continuation of therapeutic goals, so the resident does not lose their abilities. The DOR confirmed six residents had been affected.</p> <p>On 06/27/24 at 1:15 p.m., an interview was conducted with Staff C, Assistant Director of Nursing (ADON). She stated she was supposed to schedule orientation for herself and the restorative aides to understand her new role. She stated the restorative orders were stored in a binder in her office. Review of the order confirmed therapy orders had been in place. She said, We have not set up the training on the procedures of how to manage the restorative program. I did not know I was supposed to input the orders for the aides to carry out the restorative program.</p> <p>On 06/27/24 at 1:22 p.m. an interview was conducted with the Director of Nursing (DON). She confirmed the restorative program had not been implemented for newly assigned residents since the previous ADON left.</p> <p>An interview was conducted with the Nursing Home Administrator (NHA) on 06/27/24 at 02:15 p.m. She stated the residents requiring restorative should transition to the program easily. She stated the previous ADON was entering the orders. The new ADON has not learned the process yet. The NHA stated the residents should not have gone without restorative therapy. She stated they would educate the new ADON.</p> <p>Review of a policy titled, Restorative Nursing Services, dated 08/24/17 showed restorative nursing will be provided to residents as indicated upon evaluation to assist in achieving the highest practicable level of physical functioning as possible. The procedure showed therapy may refer a resident to restorative upon discharge from therapy services as deemed appropriate. When being referred by a therapist, therapist will complete a communication form to restorative nursing. Therapist will review with the restorative aide. After review the therapist restorative nurse and restorative aid was signed the form. The designated restorative nurse will determine appropriate programs and treatment utilizing information provided by various disciplines and in accordance with the residents plan of care. Restorative programs provided by restorative nursing assistants will be documented each time the program is provided on the restorative tracking form.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46234</p> <p>Based on observation, interview, and record review the facility did not ensure trauma informed care was provided for one (#114) out of three residents with post-traumatic stress disorder (PTSD).</p> <p>Findings included:</p> <p>Review of Admission Record showed Resident #114 was admitted on [DATE] with diagnoses including bipolar disorder, unspecified intellectual disabilities, anxiety disorder, major depressive disorder, post-traumatic stress disorder (PTSD), and autistic disorder.</p> <p>Review of Resident #114's Quarterly Minimum Data Set (MDS), dated [DATE], Section I, Active Diagnosis, noted yes for post-traumatic stress disorder. Section C, Cognitive Patterns, was not able to be completed due to resident rarely/never being understood.</p> <p>Review of Resident #114's care plan did not show a focus area or interventions in place related to post-traumatic stress disorder.</p> <p>An observation was conducted on 10/25/24 at 10:40 a.m. of Resident #114 lying in bed and yelling out repeatedly. Staff EE, Licensed Practical Nurse (LPN) was in the hall and said, is she still crying?</p> <p>An interview was conducted on 6/28/24 at 10:17 a.m. with the MDS Coordinator. She said she had only worked in the facility a couple of months and did not know all the residents, including Resident #114. She said if a resident had a PTSD diagnosis there isn't a specific PTSD care plan, but there is a trauma informed care focus area. She reviewed Resident #114's diagnoses and care plan. She said the resident should have a care plan for trauma informed care.</p> <p>An interview was conducted on 6/28/24 with the Nursing Home Administrator (NHA). She reviewed Resident #114's medical record and said the resident is not being followed by psychiatry or psychology. She said Resident #114's primary care nurse practitioner has mental health training and managed the resident's medications.</p> <p>Review of the policy - Trauma Informed Care, document N-1580 and effective 10/24/22, showed Residents will be evaluated to identify a history of trauma, triggers and cultural preferences. Resident- centered interventions are initiated based on the resident triggers and preferences to decrease the risk of re-traumatization. The procedure included:</p> <ul style="list-style-type: none"> <li>-1. Residents are evaluated for trauma, triggers and cultural preferences on admission/re- admission, quarterly, and annually.</li> <li>-2. Develop resident- centered interventions based on trauma triggers and resident cultural preferences.</li> <li>-3. Develop a care plan and add interventions to the nurse aide Kardex.</li> </ul> <p>(continued on next page)</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>-4. Review and update care plan and interventions quarterly and as needed.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453</b></p> <p>Based on record review and interview, the facility failed to ensure medications were administered as ordered for one resident (#393) of 42 residents on the 200 Unit.</p> <p>Findings included.</p> <p>Review of the Admission Record showed Resident #393 was admitted to the facility on [DATE] with diagnoses of traumatic hemorrhage of cerebrum, unspecified without loss of consciousness, subsequent encounter, acute respiratory failure, aphasia, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side.</p> <p>Review of the June 2024 Medication Administration Record (MAR) for Resident #393 revealed on 06/06/24 the resident was ordered Cephalexin Oral Tablet 500 mg (milligram), Give 500 mg enterally four times a day for infection (urinary tract infection) for 7 days.</p> <p>Review of the MAR showed Resident #393 received the Cephalexin antibiotic as follows:</p> <p>* On 06/07/24 at 2:50 p.m., Cephalexin 250 mg, 2 tablets were administered. Record review showed no other doses were administered on 06/07/24.</p> <p>* On 06/08/24 at 5:34 a.m., Cephalexin 250 mg, 2 tablets were administered.</p> <p>On 06/08/24 at 9:54 a.m., Cephalexin 250mg, 2 tablets were administered.</p> <p>Record review showed no other doses were administered on 06/08/24.</p> <p>* On 06/09/24 at 6:44 a.m., Cephalexin 250 mg, 2 tablets were administered.</p> <p>On 06/09/24 at 8:22 a.m., Cephalexin 250 mg, 2 tablets were administered.</p> <p>On 06/09/24 at 12:47 p.m., Cephalexin 250 mg, 2 tablets were administered.</p> <p>Record review showed no other doses were administered on 06/09/24.</p> <p>Review of the MAR for Resident #393 showed the resident did not receive the Cephalexin antibiotic as ordered from 06/10/24 to 06/13/24, which was the end of the 7 days.</p> <p>On 06/27/24 at 2:15 p.m. an interview was conducted with Staff L, Licensed Practical Nurse (LPN)/Unit Manager and the Director of Nursing (DON). The DON reviewed the resident's record and confirmed they had pulled the medication from the EDK (Emergency Drug kit). She stated they ran out of the Cephalexin that was in the EDK kit. The DON stated the nurse should have called the pharmacy to follow-up on the delivery of Resident #393's medications. She confirmed the missed doses. The DON said, She should not have missed her antibiotics. The expectation was for the nurse to contact the doctor and to notify the unit manager and DON if they did not have the antibiotics.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Regional Nurse Consultant (RNC) on 06/27/24 at 2:35 p.m., the RNC stated the nurse should have followed up on the original order and called pharmacy. She said, Yes, the EDK should be used for an emergency; not on an on-going basis. She confirmed the nurse should have contacted the pharmacy to obtain the antibiotics.</p> <p>An interview was conducted on 06/27/24 at 9:24 a.m. with the Advanced Registered Nurse Practitioner (ARNP). She reviewed Resident #393's MAR and stated it looked like they did not follow-up regarding the antibiotics. She said, They should have called the pharmacy. It seems to be a timeliness issue. They may have pulled from their EDK stock. The nurse should have notified someone if the resident did not have medications. Antibiotics are critical meds. The resident already had critical labs. It did not help her situation.</p> <p>Review of a facility policy titled, Physician Orders, dated 11/30/24, showed the center will ensure physician orders are appropriately and timely documented in the medical record. The procedure showed: information received from the referring facility or agency to be reviewed, verified with the physician and transcribed to the electronic medical record. The attending physician will review and confirm orders.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46234</p> <p>Based on observation, interview and record review, the facility did not ensure medication was stored properly for three residents (#129, #141 and #142) related to medications in resident rooms and medications on the floor, and in three medication carts (400 Low, 300 High and 200 Low) out of four medication carts audited related to undated insulin, and an unlocked medication cart.</p> <p>Findings included:</p> <p>1. An observation was conducted on 6/27/24 at 3:20 p.m. of an unlocked medication cart on the 4th floor resident hall. No staff were in the hallway at the time. At 3:34 p.m. the cart remained unlocked with no staff around. At that time an interview was conducted with Staff J, Licensed Practical Nurse (LPN)/Unit Manager (UM). She said the medication cart should not be unlocked and she would try to find the nurse assigned to that cart. At 3:39 p.m. Staff DD, LPN returned to the floor and said he didn't know his cart was unlocked and knew it shouldn't be.</p> <p>An interview was conducted on 6/27/24 at 5:10 p.m. with the Director of Nursing (DON). She said she would expect medication carts to be locked when the nurse is not with the cart.</p> <p>An observation was conducted on 6/28/24 4:57 p.m. of a pill on the floor of room [ROOM NUMBER]. (Photographic Evidence Obtained.) Staff EE, LPN was brought into the room and was observed picking up the pill. She said she did not know why the pill was on the floor as both residents in that room take their pills crushed. She said it is dangerous for it to be on the floor in the resident room.</p> <p>An interview was conducted on 6/28/24 at 5:11 p.m. with the DON. She said she would not expect there to be pills on the floor in resident rooms.</p> <p>43453</p> <p>2. On 6/25/24 at 10:33 a.m. an observation was made of three bottles of medications at the bedside in Resident #129's room. The three bottles of medications were: Zinc, Wild Omega, and Quercetin immune formula. The resident stated a family member had brought the medication in. He stated he took them on his own every day. (Photographic Evidence Obtained).</p> <p>On 6/25/24 at 10:34 a.m. an observation was made of three tablets on the floor in Resident #141's room. The resident did not have any idea there was medication on the floor. (Photographic Evidence Obtained).</p> <p>On 6/25/24 at 1:24 p.m. an observation was made of an Albuterol Sulfate inhaler on Resident #142's walker which was positioned by the side of his bed. The resident stated he used it every 6 hours for shortness of breath (Photographic Evidence Obtained).</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/25/24 at 10:40 a.m. Staff X, Certified Nursing Assistant (CNA) observed medication on the floor in Resident #141's room. She stated that was not good. Staff X stated if she saw medications on the floor, she would not touch them. She stated she would notify the nurse. Staff X said, The resident must have refused to swallow them. At this time an interview was conducted with Staff I, Licensed Practical Nurse (LPN). She proceeded to remove medications from the floor in Resident #141's bedside. She stated she would call the doctor. She confirmed the three tablets were two Senna tablets and one vitamin D. She stated they were not from her shift. She said, They must have been from last night. The nurse should have stayed with the resident. Staff I, LPN removed the medications from Resident #141's room. She stated she would call the doctor.</p> <p>An interview was conducted on 6/25/24 at 10:46 a.m. with the Advanced Registered Nurse Practitioner (ARNP). She stated the resident should not have medications at bedside without orders. She stated they should be removed, and the nurse should notify the doctor to get a script if needed if the medications were not offered. She stated there should be no tablets on the floor. She said, That is not good.</p> <p>On 6/25/24 at 10:42 a.m. Staff L, LPN U/M observed the bottles of medications removed from Resident #129's room. She stated she did not know the medications were in the room. She confirmed she worked this hall every morning and conducted room rounds throughout the day. She stated she would call the doctor to obtain orders for the medications at bedside. She confirmed the resident's medications should not be unsecured in the resident rooms. She stated nurses should supervise residents during medication administration.</p> <p>Review of a facility policy titled, Medication and Medication Supply Storage and Disposal, dated 11/30/14, showed central storage of medications is required for prescription, prescribed over the counter medications and CAM (Complementary and Alternative Medicine), will be kept in a locked area in their original labeled container, and may not be removed more than two hours prior to the scheduled administration time. Medications will be kept in a medication cart that locks, and keys are only accessible to the licensed personnel distributing medications. Only current medication for individuals living in the residence will be kept in the residence.</p> <p>37999</p> <p>3. Observation of the 300 High medication cart was conducted on 6/28/24 at 4:34 p.m. with Staff D, Registered Nurse (RN). The observation revealed a medication cup containing crushed medications mixed with applesauce located in a plastic tray in a drawer of the cart. The observation revealed three undated vials of Novolog insulin, 1 undated vial of Lantus insulin, 1 undated vial of Fiasp insulin, 1 undated Novolin 70/30 Flexpen, and an undated vial of Latanoprost Ophthalmic 0.005% solution. (Photographic Evidence Obtained)</p> <p>Observation of the 200 Low medication cart was conducted 6/28/24 at 5:03 p.m. with Staff F, RN. The observation revealed an unopened bottle of Insulin Glargine stored with other opened insulin containers. The bag holding the unopened vial showed the vial was opened on 6/25/24. An opened undated vial of Insulin Glargine and an opened undated vial of Insulin Aspart were observed in the medication cart. (Photographic Evidence Obtained)</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the manufacturer website, <a href="https://www.novomedlink.com/">https://www.novomedlink.com/</a>, showed the medication Fiasp, once opened can be stored for a maximum of 4 weeks (28 days). The manufacturer website, <a href="https://www.novomedlink.com/">novomedlink.com</a>, showed Novolog should be disposed of 28 days after opening. The website, <a href="https://www.lantus.com/">lantus.com</a>, revealed opened vials of Lantus should be thrown away after 28 days, even if it still has insulin left in it. The Mayo Clinic, <a href="https://www.mayoclinic.org">www.mayoclinic.org</a>, showed Latanoprost Ophthalmic solution can be stored in the refrigerator or at room temperature for up to 6 weeks.</p> <p>An interview was conducted on 6/28/24 at 5:07 p.m. with the Director of Nursing (DON). The DON stated insulin should be dated on the tag attached to the vial, Lantus (unopened) should be refrigerated, and crushed medications should have been destroyed.</p> <p>Review of the policy titled, Medication and Medication Supply Storage and Disposal, effective 11/30/2014, document ALF-935, showed medications would be kept in a locked area, in their original labeled container, and may not be removed more than 2 hours prior to the scheduled administration. Meds will be kept in a medication cart that locks and keys are only accessible to the licensed personnel distributing medications. Medication will be stored in a(n) organized manner under proper conditions and in accordance with manufacturer's instructions.</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43453</p> <p>Based on record review and interview, the facility failed to ensure critical labs were reported to the ordering physician in a timely manner for one resident (#393) of 53 residents sampled.</p> <p>Findings included:</p> <p>Review of the Admission Record showed Resident #393 was admitted to the facility on [DATE] with diagnoses of traumatic hemorrhage of cerebrum, unspecified without loss of consciousness, subsequent encounter, acute respiratory failure, aphasia, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side.</p> <p>Review of laboratory results for Resident #393 showed:</p> <p>On 6/10/24 at 6:15 a.m. labs were collected.</p> <p>On 6/10/24 at 8:55 a.m. labs were received.</p> <p>On 6/10/24 at 1:44 p.m. lab results were reported to the facility.</p> <p>Review of the lab results showed the following high readings that were flagged.</p> <p>Glucose serum 193; Reference range 70-105; Flagged high results.</p> <p>BUN (Blood Urea Nitrogen) 59; Reference range 7-25 Flagged high results.</p> <p>Sodium Serum 155; Reference range 135-145; Flagged high results.</p> <p>Chloride 113; Reference range 98-108; Flagged high results.</p> <p>Osmolarity Calculated 343.9; Reference range 275.0-295; Flagged high results.</p> <p>Review of Resident #393 progress notes and assessments showed there were no progress notes documented on this day to confirm the resident's physician was notified.</p> <p>Review of a hospital document titled, History and Physicals, Final Report, dated 06/13/24, showed the patient presented to the emergency room (ER) with abnormal labs. The resident was previously discharged to a facility. She returned to the ER secondary to having abnormal labs. Upon evaluation the patient was lethargic. When her labs were drawn, she had an increase in her white count of 18,000. Her BMP (Basic Metabolic Panel) showed her sodium was 160 and Potassium was 6. Her BUN was 134 and creatine was 2.76, which were previously normal. Patient received IV fluid per Sepsis protocol and broad- spectrum antibiotics. Patient was admitted to the Intensive Care Unit (ICU) for further evaluation and work up.</p> <p>(continued on next page)</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/27/24 at 09:09 a.m., an interview was conducted with the facility's ARNP (Advanced Registered Nurse Practitioner). She stated she had to send the resident out due to critical labs on June 13th. She stated the resident's sodium level was 155 and her BUN (kidney function) was 59. The ARNP stated she had re-ordered labs on the 13th because she had critical labs that were not addressed on the 10th. The ARNP said, I don't know why the physician was not notified. I don't know that they notified anyone. The ARNP stated if the lab results were critical, they should be reviewed STAT, meaning without delay. She said, Typically when I come in, I review the labs myself because most of the time they do not call. They also don't answer the phone. The ARNP stated the facility nurse should call with any critical labs. She stated a delay of 24 hours can make a significant difference for a resident. The ARNP said, I have told the administration they can call me. It is a problem that they don't call when the resident has a change in condition. The ARNP stated communication was a problem at this facility.</p> <p>On 06/27/24 at 11:16 a.m. an interview was conducted with the Director of Nursing (DON). The DON said, She [Resident #393] had critical labs. The nurse should notify the physician, put in orders and notes as soon as they receive the labs. The DON stated there should be a progress note if the physician was notified. The DON stated the laboratory provider called the facility, but it was a hit or miss process. The DON stated the laboratory provider sent a fax too. The DON confirmed the facility had access to the laboratory results. She said, We can log in and look. The DON stated the expectation was for the nurse to call the doctor as soon as the results were received, obtain orders, and document. She said, That is Nursing 101. The DON stated the resident should not have waited 24 hours for a response to critical labs.</p> <p>On 06/27/24 at 11:34 a.m. an interview was conducted with Staff L, Licensed Practical Nurse (LPN). She stated the nurses should notify the doctor of any critical labs and immediately put it in a progress note. She stated the physician should be called as soon as they review the labs.</p> <p>Review of a facility policy titled, Laboratory, Diagnostic and X-ray, dated 11/30/2014, showed an expectation to provide guidance on ordering, obtaining, documenting and reporting laboratory, diagnostic and X-ray results. Under procedure:</p> <ul style="list-style-type: none"> <li>*Critical values to be called to the center.</li> <li>* The center to notify the ordering practitioner (or the covering physician if after hours) of values outside the reference range or per physician order.</li> <li>* Document any new orders.</li> <li>* Document notification of the practitioner and resident/resident representative of lab work results, diagnostic testing and X-rays to be filed in the electronic medical record.</li> </ul>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37999</p> <p>Based on observation, record review, and interview the facility failed to promptly provide dental services for one (#79) out of one sampled resident complaining of chewing difficulties related to tooth pain.</p> <p>Findings included:</p> <p>On 6/25/24 at 10:53 a.m. Resident #79 was observed lying in bed. The resident reported having no teeth, having a problem chewing, and had told everybody about the chewing problem.</p> <p>Review of Resident #79's Admission Record revealed the resident was originally admitted on [DATE] and readmitted on [DATE] and 11/29/22. The record included diagnoses not limited to unspecified Type 2 diabetes mellitus with unspecified complications, mild protein-calorie malnutrition, and gastro-esophageal reflux disease without esophagitis. The Admission Record revealed the primary payer source for the resident was Medicaid (MCD) Long Term Care (LTC) [provider name].</p> <p>Review of Resident #79's Quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating a severe cognitive impairment. The assessment revealed the resident was not edentulous, did not have any abnormal mouth tissues (ulcers, masses, oral lesions), no obvious or likely cavity or broken natural teeth, no inflamed or bleeding gums, or any mouth or facial pain, discomfort or difficulty with chewing.</p> <p>Review of Resident #79's medical record revealed a note, dated 5/28/24, showing the resident reported pain in a tooth, the Nurse Practitioner was notified, and an order was obtained for a dental consult and Acetaminophen.</p> <p>Review of Resident #79's progress notes showed the resident received two tablets of 325 mg (milligram) Acetaminophen on 6/4/24 at 11:18 p.m., 6/21/24 at 9:07 a.m., and 6/27/24 at 7:20 a.m., per an order for every 6 hours as needed for pain. The note did not reveal the location of the resident's pain.</p> <p>An interview was conducted with the Social Service Assistant (SSA) on 6/26/24 at 5:13 p.m The SSA reported having to check if dental had been in. The SSA stated the dentist comes in once a month, and the hygienist comes in once a month. The SSA stated she would have to check if dental had been in the facility twice during the month of June. The SSA stated dental services are supposed to write a note if the resident refuses and it gets uploaded (into the resident's clinical record). The SSA reviewed records and stated the dentist was at the facility on 5/29/24 (the day after Resident #79 had reported tooth pain) and the facility had to request an appointment. A request was made for any dental notes and information if Resident #79 had been seen on 5/29/24.</p> <p>On the morning of 6/27/24 the Director of Nursing was asked for the dental information requested of the SSA on 6/26/24.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/27/24 at approximately 5:00 p.m. a request was made to the Regional Nurse Consultant (RNC) for the previously requested dental information related to Resident #79. The RNC stated they were trying to get a dental appointment for the resident.</p> <p>On 6/27/24 at 5:28 p.m. another request was made to the DON regarding Resident #79's dental information (notes, appointments) and she stated the hygienist had been in the facility.</p> <p>On 6/27/24 at 6:15 p.m. a request was made to the DON asking if Resident #79 had been seen by dental services.</p> <p>Review of Resident #79's progress notes revealed a note written by the DON, dated 6/27/24 at 6:36 p.m., showing the resident had a 10 a.m. dentist appointment at an outside dental vendor. The note did not reveal a date of the appointment.</p> <p>Review of Resident #79's progress note, dated 6/27/24 at 7:09 p.m., showed the resident refers [sic] to continue with dental pain, the physician was notified with orders for Acetaminophen and labs obtained. The note revealed the resident had a dental consult appointment scheduled.</p> <p>An interview was conducted on 6/28/24 at 8:35 a.m. with the DON. The DON stated they attempted to reach out to the dental vendor yesterday but it had been after 5:00 p.m., so they were closed; and the hygienist should have given a list (of residents seen) to Medical Records but did not know what happened.</p> <p>On 6/28/24 at 9:10 a.m. Resident #79 was observed dressed, sitting in a wheelchair, and waiting to leave the facility for a dentist appointment. The resident reported not having any teeth, opening mouth and revealing 4-5 blackened broken teeth on the bottom. The resident stated her mouth continued to hurt.</p> <p>The facility did not provide supporting documentation to show Resident #79 had been seen by dental services during the month of May or June. The facility did provide documentation that the resident had been seen at an outside the facility dental vendor on 6/28/24, 32 days after the resident complained of tooth pain on 5/28/24.</p> <p>Review of the Policy and Procedure titled, Dentist Services, revised 11/27/17, showed The center will contract with a dentist licensed by the board of dentistry to provide routine and 24- hour emergency dental services. The procedures instructed:</p> <ul style="list-style-type: none"> <li>- Obtain order for dental consult.</li> <li>- The nurse or designee will if necessary or if requested assist the patient/ resident in making the appointment and arranging for transportation to and from the dentist's office.</li> <li>- Residents with lost or damaged dentures will be referred promptly within three days to the dentist.</li> <li>- If a referral does not occur within three days the nurse will evaluate and document changes inability to eat and drink. Review ability with physician and obtain orders as indicated.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Medicare and private pay residents may be charged for the services. The facility will provide Medicaid resident services in routine services covered under the state plan at no charge. If any resident of the facility is unable to pay for needed dental services, the facility will attempt to find alternative funding sources or alternative service delivery systems to ensure the resident maintains his/ her highest practicable level of well-being.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50434</b></p> <p>Based on record review, observation and interview the facility failed to ensure the kitchen was clean and free of expired food(s) of one kitchen.</p> <p>Findings included:</p> <p>An initial tour of the kitchen on [DATE] at 9:45 a.m. revealed:</p> <ul style="list-style-type: none"> <li>*A blue lighter on the top of the handwashing sink;</li> <li>*A silver pan with a brown substance along the enteral edges and sudsy water located on a basket under the hand washing sink;</li> <li>*The first compartment of the three-compartment sink had dirty dishes in it, the second compartment had frozen chicken defrosting with a silver pan and a cutting board located underneath, and the third compartment had dirty dishes soaking in it. (Photographic Evidence Obtained)</li> </ul> <p>Further observations during the tour with the Certified Dietary Manager (CDM) on [DATE] at 10:00 a.m. revealed:</p> <ul style="list-style-type: none"> <li>*In the reach-in cooler: a silver pan filled with a red thick liquid and was covered with a plastic wrap with a white label that showed sauce with a use by date of ,d+[DATE], a white block of an unknown food item with a white label that documented ,d+[DATE] (there was no indication if this was the open date or use by date a bag of open instant mashed potatoes with no date, and two desert bowls with plastic lids and filled with a food item and no date;</li> <li>*A water heater located under the dish machine and with the front panel missing and exposed wires and insulation;</li> <li>*Two dish racks on their side, on the ground with a white bucket in the middle underneath the dish machine and next to the water heater with exposed wires; and</li> <li>*A brown rust likes substance on the outer front bottom corner of the dish machine. (Photographic Evidence Obtained)</li> </ul> <p>On [DATE] at 12:00 p.m. the kitchen was toured with the Regional CDM and revealed:</p> <ul style="list-style-type: none"> <li>*A yellow mop bucket with a mop and gray water touching the white plastic piping of a clean dish rack with clean plate covers;</li> <li>*An unlabeled, opened bag of mashed potatoes mix was on top of the window air conditioning (AC) unit;</li> <li>*An opened bag of grits located under the stove on a shelf;</li> </ul> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>*An AC vent with black bio growth on it and located over clean dishes;</p> <p>*A maroon windbreaker jacket was touching a green wired shelf that contained cups and lids on the green wire shelf;</p> <p>*On a shelf under the food preparation station, an opened blue bag had a pair of shoes that were exposed and next to a jar of peanut butter and two jars of seasoning. (Photographic Evidence Obtained)</p> <p>During an interview on [DATE] at 2:00 p.m. the photographic evidence was shared with the Nursing Home Administrator, Regional CDM, and CDM. The Regional CDM stated he thought the pan under the hand washing sink was from breakfast and was put under the sink to be washed. He stated it was not his expectation for dirty dishes. He stated food that was opened or left over and put into the reach-in cooler has a 5-day shelf life. He stated he was not sure why the water heater had the panel removed. It was requested to be put back on this week and they are working on getting it removed from the kitchen. The CDM stated he was not sure where the lighter came from, and he does not expect to find lighters near the handwashing station. He stated when chicken is being thawed, he would expect it to be in a pan in the refrigerator and not in the sink with dirty dishes. He expected any outdated food to be removed by the use by date or expired date. He stated food was labeled with dates of when the items were opened or put in the fridge.</p> <p>Review of the Kitchen Cleaning Schedule, dated [DATE], revealed:</p> <p>Week 1 ([DATE]rd-7th ) Monday, Thursday, and Friday there were no entries.</p> <p>For Week(s) 2, 3 and 4 there were no entries in any day.</p> <p>Review of the policy titled, Receiving, Procedures, dated ,d+[DATE], revealed: 5. All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation. 6. All food items will be stored in a manner that ensures appropriate and timely utilization based on the principles of first in-first out (FIFO) inventory management.</p> <p>Review of the policy titled, Food Storage: Cold Foods, Procedures, dated ,d+[DATE], revealed: 5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.</p> <p>Review of the policy titled, Equipment, dated ,d+[DATE], revealed the policy statement as, All foodservice equipment will be clean, sanitary, and in proper working order. 1. All equipment will be routinely cleaned and maintained in accordance with manufactures directions and training materials All non-foods contact equipment will be cleaned and free of debris.</p>		

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NAME OF PROVIDER OR SUPPLIER  Aspire at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE  2916 Habana Way Tampa, FL 33614	
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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>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37999</p> <p>Based on observation, record review, and interview the facility failed to ensure the medical record of one (#90) out of fifty-three sampled residents was accurate related to the application and removal of an orthotic device.</p> <p>Findings included:</p> <p>On 6/25/24 at 10:27 a.m. Resident #90 was observed lying in bed with his right arm bent at the elbow, right hand and wrist were visible and lying on the resident's chest. The observation showed the resident's right wrist was bent and the fingers were in a fixed fist-like position, and the thumbnail extended approximately 0.25 inches past the fingertip. The resident stated staff try to open my hand to clean underneath (the clenched fingers).</p> <p>On 6/26/24 at 11:20 a.m. Resident #90 was observed lying in bed and not wearing a splint/brace and/or holding a hand roll in his right hand. The resident reported not wearing a splint or hand roll.</p> <p>On 6/26/24 at 2:37 p.m. Resident #90 was observed lying in bed and was not wearing either a splint/brace or holding a hand roll.</p> <p>On 6/26/24 at 3:16 p.m. Resident #90 was observed lying in bed and was not wearing either a right-hand splint/brace or holding a hand roll.</p> <p>On 6/27/24 at 11:53 a.m. Resident #90 was observed lying in bed and not wearing a splint/brace on right hand.</p> <p>Review of Resident #90's Admission Record revealed the resident was admitted on [DATE] and included diagnoses not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, contracture of right hand, right knee, and right hip, and not elsewhere classified stiffness of right and left knee.</p> <p>Review of Resident #90's active physician orders as of 6/27/24 at 6:47 p.m. revealed the following orders:</p> <ul style="list-style-type: none"> <li>- Restorative Passive Range of Motion (PROM)/Active-assisted Range of Motion (AAROM) to bilateral lower extremities 2x (times)10, 3x/week for 6 weeks as tolerated, active as of 11/8/23.</li> <li>- Right hand splint on AM and off PM, every day shift for muscle strength related to Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, active as of 4/27/22.</li> </ul> <p>Review of Resident #90's physician orders showed the order for the resident's application and removal of the right-hand splint was listed on the June 2024 Treatment Administration Record (TAR). Review of the TAR showed the licensed nursing staff documented the order had been administered daily, except for 6/20/24.</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>Review of Resident #90's June 2024 Medication Administration Record (MAR) did not reveal the resident had exhibited any behaviors from 6/1/24 to 6/26/24 day shift.</p> <p>Review of Resident #90's Restorative Nursing Program documentation, dated 5/29/24, showed under Problems/Needs: the right upper extremity (RUE) was painful especially elbow &amp; hand, severe right (R) hand contracture, and Refuses to trial any right splints. The Recommendations/Approaches included: staff to perform Left (L) UE AROM (active range of motion) 10 reps 2 sets for shoulder flexion, elbow ext (extension)/flexion, wrist &amp; finger extension 5 repetitions 2 sets and Gentle PROM right shoulder, elbow &amp; hand within tolerance every (q) pain. The Precautions revealed: Patient may refuse any ROM to right arm.</p> <p>Review of Resident #90's Visual/Bedside Report revealed the Restorative care areas:</p> <ul style="list-style-type: none"> <li>- Nursing Rehab/Restorative: Splint/Brace Right hand on a.m. (AM) and off p.m. (PM) daily.</li> <li>- Restorative: PROM/AAROM to bilateral lower extremities (BLE) 2x 10, 3x/week for 6 weeks as tolerated.</li> <li>- Restorative: Right hand splint on a.m. and off p.m. every day shift for muscle strength related to Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.</li> <li>- Right hand splint to be worn daily as follows: On in a.m. and off in p.m., Check skin for redness or breakdown.</li> </ul> <p>Review of Resident #90's care plan, revised on 10/23/23, revealed the resident had an Activity Daily Living (ADL) self-care performance deficit related to Hemiplegia, Impaired balance, Limited ROM, (and) Stroke. The interventions associated with the focus included: Restorative - Right-hand splint on AM and off PM every day shift.</p> <p>An interview was conducted on 6/27/24 at 2:25 p.m. with Staff T, Restorative Certified Nursing Assistant (RCNA). Staff T reported doing restorative over [AGE] years at the facility. Staff T stated Resident #90 did not have a splint, received ROM when the resident allowed, the Director of Rehabilitation ordered ROM for the (right) arm but the resident refuses. Staff T reported not thinking the hand ROM (orders) were in the computer so does only the resident's legs. Staff T stated the resident had a splint at one time, but it had been discontinued. Staff T returned to the interview on 6/27/24 at 2:31 p.m., and reported after reviewing the Restorative Record for Resident #90, she performed lower extremity ROM only and did it for 5 minutes. Staff T stated if the resident had a splint she would be the one who applied it.</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>An interview was conducted on 6/27/24 at 3:24 p.m., with Staff V, Registered Nurse (RN), the floor nurse for Resident #90. Staff V reported Resident #90 did have a right-hand splint/brace and received therapy. An observation was conducted of Resident #90 with Staff V at this time. The resident was not wearing a splint/brace and/or hand roll. Resident #90 reported Restorative had not come and Staff V stated therapy applies the splint/brace then said, not today. Staff V reviewed Resident #90's Admission Record showing the resident had a diagnosis of hemiplegia and stated yes she put the splint on the resident, who wears it 1-2 hours then takes it off. Staff V reported taking Resident #90's splint off at 2:00 p.m. (prior to the interview). The interview continued at the bedside of the resident and Staff V reported putting the splint on the resident and when it wasn't available she put it (right hand) on a pillow. Resident #90 shook head and stated he did not have a splint. Staff V reviewed the TAR and confirmed signing the TAR showing she put the splint on.</p> <p>Review of Resident #90's Minimum Data Set (MDS) assessment, dated 4/4/24, revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating severe cognitive impairment. The resident was observed and interviewed throughout the survey process and answered questions appropriately. The review showed during the 7-day period prior to 4/4/24 the resident did not receive any PROM, AROM, or splint/brace assistance.</p> <p>During an interview on 6/27/24 at 5:28 p.m. the Director of Nursing (DON) reviewed Resident #90's physician orders and stated the splint/brace (orders) should be discontinued if the resident did not have it and staff should not be documenting the resident does have it.</p> <p>Review of the job description for Clinical Nurse I (RN) revealed, As the company Clinical Nurse I-RN, you are entrusted with the responsibility of caring for our residents, families, co-workers, visitors, and all others. The primary purpose of your position is to provide direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the director of clinical services to ensure that the highest degree of quality care is maintained at all times. You are entrusted to provide innovative, responsible health care with the creation and implementation of new ideas and concepts that continually improve systems and processes to achieve superior results. The Duties and Responsibilities (of the Clinical Nurse I) included:</p> <ul style="list-style-type: none"> <li>- 4. Conduct and document a thorough assessment of each resident's medical status upon admission and throughout the resident's course of treatment.</li> <li>- 6. Comply with the evaluation, treatment, and documentation of the company guidelines.</li> <li>- 8. Complete required documentation in an accurate and timely manner.</li> <li>- 14. Monitor compliance with resident record documentation, as directed.</li> </ul>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37999</p> <p>Based on observations, record reviews, and interviews the facility failed to post correct infection control signage in resident rooms on 2 (3rd and 4th) of 3 facility floors including for Residents #37, #77 related to not correctly informing staff necessary precautions to take to prevent cross contamination of infections between residents.</p> <p>Findings included:</p> <p>An observation was conducted on 6/25/24 at 2:06 p.m. of Resident #37's open door. The door was posted Airborne Precautions, Everyone must: Clean their hands, including before entering and when leaving room, Put on a fit tested N-95 or highest level respirator before room entry, Remove respirator after exiting the room and closing the door, Door to room must remain closed. A container hanging from the doorway contained yellow isolation gowns, a package of surgical masks and a box of non-latex gloves.</p> <p>On 6/25/24 at 2:15 p.m., an observation was made from the open door of a Staff G, Certified Nursing Assistant (CNA) in the room, near the resident's bed wearing a yellow gown, surgical mask and gloves. The staff member left the room and went into the unit's common area to sanitize hands.</p> <p>Review of Resident #37's Admission Record revealed the resident was admitted on [DATE] and readmitted on [DATE]. The physician orders for the resident showed an order, dated 5/15/24, for Enhanced Barrier precautions every shift for Colonized Candida Auris.</p> <p>During an interview on 6/25/24 at 3:51 p.m., the Director of Nursing (DON) stated the facility did not have anyone under Droplet or Airborne precautions. The DON stated staff wouldn't know the type of precautions, staff should follow what the (posted) sign said, and the facility would not be able to admit anyone with Airborne precautions.</p> <p>An interview was conducted on 6/25/24 at 4:04 p.m. with Staff A, Registered Nurse (RN). The staff member reported Resident #37 was on Contact precautions and they wear a gown, gloves, and a procedure mask for the resident. Staff A reported not wearing a N-95 and the resident was currently on Contact due to a wound. The staff member stated the resident had previously been on Airborne precautions due to Candida Auris (C. Auris). Staff A reviewed Resident #37's physician orders which contained an order for Enhanced Barrier precautions. The staff member stated previously the resident had both contact and enhanced precautions due to a wound infection.</p> <p>An interview was conducted on 6/25/24 at 4:13 p.m., with Staff B, CNA. The staff member reported relying on the sign on door to show what type of Personal Protective Equipment (PPE) to wear.</p> <p>An interview was conducted on 6/25/24 at 4:14 p.m., with Staff C, RN/Assistant Director of Nursing (ADON). The ADON reported not knowing why the Airborne sign was posted (on the door to Resident #37's room) and would definitely expect staff to question why room was posted with Airborne precautions.</p> <p>46234</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 - Few</p>	<p>2. An observation was conducted on 6/25/24 at 10:00 a.m. during a tour of the fourth floor of rooms 409, 410, 412, and 415, all with contact precaution signs on the door. room [ROOM NUMBER] had a precaution sign on the door in Spanish but did not have a sign in English. (Photographic evidence obtained)</p> <p>An interview was conducted on 6/25/24 at 10:07 a.m. with Staff EE, LPN. She said the only rooms on contact precautions were room [ROOM NUMBER] and 413; the other rooms had enhanced barrier precautions.</p> <p>An observation was conducted on 6/25/24 at 12:53 p.m. of a lunch tray being delivered and set up in room [ROOM NUMBER]. There was a contact precaution sign on the door and the staff member delivering the lunch tray did not don personal protective equipment (PPE) when entering the room.</p> <p>An interview was conducted on 6/25/24 at 1:00 p.m. with Staff P, RN. She reviewed the orders for the residents in room [ROOM NUMBER] and said the room should not have a contact precaution sign; the room was standard precautions.</p> <p>A list of transmission-based precautions (TBP) provided by the Director of Nursing (DON) showed four rooms in the facility on TBP, all of which were contact precautions. Those rooms were 220, 409, 413, and the room of Resident #77.</p> <p>An observation was conducted on 6/25/24 at 2:10 p.m. of Resident #77's room with no contact precaution sign posted. An enhanced barrier sign was posted on the door. room [ROOM NUMBER] had an English enhanced barrier sign and a Spanish contact precaution sign. (Photographic evidence obtained)</p> <p>Review of Admission Records for Resident #77 showed he was admitted on [DATE] with diagnoses including paraplegia and multiple contractures.</p> <p>Review of Resident #77's labs, showed a wound culture collected on 6/21/24, was reported to the facility on [DATE] as having Methicillin Resistant Staphylococcus Aureus (MRSA).</p> <p>Review of orders showed an order for contact precautions was not put in the computer until 6/25/24 at 1:30 p.m. by the Assistant Director of Nursing (ADON).</p> <p>An observation was conducted on 6/25/24 at 2:10 p.m. and again on 6/26/24 at 11:05 a.m. and 3:15 p.m. of Resident #77's room continuing to only have an enhanced barrier precaution sign and no contact precaution sign.</p> <p>An interview was conducted on 6/25/24 at 3:50 p.m. with the DON. She said the ADON or nurse that admits the resident or receives lab results should place the correct precaution sign on a resident's door if it is required. The DON said if the sign is not correct staff wouldn't know what to do and it would cause confusion. She said, If the sign is there, staff should be following what is on the sign, even if the sign is not correct per the orders. The DON said no resident in the facility is on airborne precautions because the facility does not accept those residents. She said she will have the ADON check the precaution signs and make sure they are correct. She said it sounds like someone was just grabbing signs and putting them up.</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 - Few</p>	<p>An interview was conducted on 6/26/24 at 3:16 p.m. with Staff GG, RN. She said when a resident is on contact precautions, PPE should be worn anytime a staff member enters the room. She said for enhanced barrier staff wear gloves, gowns, and masks when working directly with the resident. Staff GG said administration staff place the correct precaution signs on the door. She reviewed the orders for Resident #77 and confirmed he should be on contact precautions and only had an enhanced barrier sign posted on his door. Staff J, LPN/Unit Manager (UM) joined the interview confirming Resident #77's order and that the incorrect sign was posted. Staff J said the ADON, who is the infection preventionist, does all the precaution signs.</p> <p>A follow-up interview was conducted on 6/26/24 at 3:37 p.m. with the DON. She reviewed Resident #77's record and said when the lab results were reported on 6/24/24 an order for contact precautions should have been entered in the computer and a sign put on the door. The DON said she teaches staff that it doesn't matter if the room is on contact or enhanced barrier precautions, they should wear PPE anytime they enter the room.</p> <p>An interview was conducted on 6/28/24 at 5:24 p.m. with the ADON. She said when a resident is on contact precautions, she puts an enhanced barrier precaution sign in English and in Spanish and she puts a contact precaution sign in English and in Spanish. She said she could see how that might cause some confusion. She reviewed Resident #77's record and confirmed he should have been placed on contact precautions when the lab results were reported on 6/24/24. She said she put the order in on 6/25/24 and does not know why the sign didn't get put up. The ADON said she conducts rounds every morning and checks all precaution signs. When asked about a resident having an airborne precaution sign she said I saw that the other day. I don't know where that came from.</p> <p>Review of a facility policy titled Policies and Practices-Infection Control, revised October 2018, showed the following:</p> <p>Policy Statement</p> <p>This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections.</p> <p>Policy Interpretation and Implementation</p> <p>1. This facility's infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteer workers, and the general public alike, regardless of race, color, creed, national origin, religion, age, sex, handicap, marital or veteran status, or payor source.</p> <p>2. The objectives of our infection control policies and practices are to:</p> <p>.</p> <p>c. Establish guidelines for implementing Isolation Precautions, including standard and transmission-based precautions.</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 - Few</p>	<p>d. Establish guidelines for the availability and accessibility of supplies and equipment necessary for standard and transmission-based precautions.</p> <p>.</p> <p>4. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37999</p> <p>Based on observation, record review, and interview the facility failed to provide a pest-free environment on two of four residential units (Hall 200 and Hall 300) and the kitchen of the facility.</p> <p>Findings included:</p> <p>An observation was conducted on 6/25/24 at 10:17 a.m. of numerous small flying black gnat like insects sitting on the bedside dresser in room [ROOM NUMBER]. (Photographic Evidence Obtained) One of the two residents currently in the 4-person room, nodded his head up and down when was asked if the facility had flying insects.</p> <p>An observation was conducted on 6/27/24 at 8:38 am., during the task of medication administration on the 300 Hall, of a black flying insect flying around the cart.</p> <p>On 6/28/24 at 9:02 a.m. the Director of Maintenance stated the facility had installed bug zapping lights that have blue lights if they are on. The Director of Maintenance stated he noticed the breaker for the 2nd and 3rd floors had been tripped. The observation showed the bug light on 3 High was unplugged, the Director of Maintenance stated staff unplug the light to plug in their phones, and plugged the light back in.</p> <p>43453</p> <p>2. During a facility tour of the 200 Hall on 06/25/24 at 10:13 a.m. an observation was made of small flying gnat like insects in room [ROOM NUMBER]. The resident stated this has been an ongoing problem.</p> <p>On 06/25/24 at 1:38 p.m. the Director of Maintenance observed the flying insects on the resident's bedside table and on the cups. He stated, This is not good at all. The gnats have been an ongoing problem. He stated one of the residents in room [ROOM NUMBER] liked to hold on to food. The Director of Maintenance said, There are quite a few gnats here. I will call pest control.</p> <p>On 06/25/24 at 2:20 p.m. during an interview with the Nursing Home Administrator (NHA) small flying gnat like insects were observed in the facility's conference room. She stated they hold care plan meetings in this room. She stated they have had problems with gnats. She stated in response they have increased pest control visits. The NHA stated they had received complaints in April 2024 and May 2024. She stated they addressed the grievances. She stated the Ombudsman had voiced concerns.</p> <p>Review of the Grievance Logs for April - June 2024 revealed ongoing concerns related to pest sightings. On 05/14/24 the Ombudsman filed a grievance to have the pest control company spray all rooms and the kitchen for fruit flies and roaches.</p> <p>(continued on next page)</p>		

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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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/26/24 at 3:20 p.m. an interview was conducted with Staff L, Licensed Practical Nurse (LPN)/Unit Manager. During the interview small flying gnat like insects were observed in the 200 Hall. Staff L was observed swishing the pests off her face. She said, They have these annoying flies everywhere. It is worse in room [ROOM NUMBER] because the resident hides food. Staff L, LPN/Unit Manager stated the Director of Maintenance had installed light fixtures to catch the flies. She said, I don't know if they are working, but I see a few gnats inside the trap.</p> <p>During a tour of the kitchen on 06/27/24 at 12:07 p.m. an observation was made of standing water on the floor around missing tiles in the kitchen. The water was noted with an odor and flies were observed hovering on the trash can, around the standing water and on food carts at the dishwashing station.</p> <p>An immediate interview was conducted with the Certified Dietary Manager (CDM)/Kitchen Manager. He stated they had an ongoing problem of flies because of the standing water. He stated maintenance was supposed to fix the tiles and spray the drains. He observed the flies and stated this was not proper sanitation. The CDM stated sometimes they pour vinegar down the drain to ease the smell and keep away the fruit flies. He stated maintenance had been notified.</p> <p>On 06/28/24 at 9:37 a.m. the Director of Maintenance stated the contractor came in weekly. He stated he sprayed all areas where there were sightings. He stated they sprayed fly traps. He stated the problem in the kitchen was that staff were turning off the fly lights. He stated he sprayed bacteria eater, whenever he saw gnats and roaches. The Director of Maintenance stated the residents' wellness was his priority.</p> <p>Review of a document titled, Pest Sighting Log showed entries documented for the month of May 2024 for sightings of gnats and roaches in halls 200, 300, 400 and Kitchen (100 hall). Page 2 of the log showed between 12/19/23 to 03/21/24 there were seven sightings of gnats, roaches, fleas, and bugs documented.</p> <p>On 06/28/24 at 9:43 a.m. the Director of Maintenance stated the staff were inconsistent with reporting sightings. He stated this was a struggle. He said, They are not doing a good job.</p> <p>Review of a facility policy titled, Pest Control, dated 11/30/2014, showed the facility will maintain a pest control program which includes inspection, reporting and prevention.</p> <p>Procedure:</p> <ol style="list-style-type: none"> <li>1. A pest control contract will be maintained with a licensed exterminator.</li> <li>2. The contract will include routine quarterly inspections.</li> <li>3. Treatment will be rendered as required to control insects and vermin.</li> <li>4. Any unusual occurrence of sighting of insects should be reported immediately to the supervisor. Proper action will be taken.</li> </ol>		