STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105419	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Oldsmar	3865 Tampa Rd Oldsmar, FL 34677

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observations, interviews, and record review, the facility failed to ensure residents were from significant medication errors for 14 (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, and #14) of 32 residents who evacuated from Facility A to Facility B, for four of four days reviewed (10/18/24, 10/19/24, 10/20/24 and 10/21/24). Findings included: 1. During a post storm assessment tour conducted on 10/21/24 at 3:10 p.m., Resident #1 was heard from the hallway screaming and yelling. An observation revealed the resident lying on her bed making twisting and turning movements on the bed. The resident did not respond to the interview. An immediate interview was conducted with Staff A, Registered Nurse (RN) assigned to Resident #1 on 10/21/24 at 3:10 p.m. She stated she was not familiar with the resident because she was one of the evacuees from Facility A. Staff A stated the resident had been loud and agitated all day. Staff A said, The only problem I have is that she does not have her medications. She is supposed to receive Hydrocodone-Acetaminophen 10-325 mg for pain. Staff A confirmed this resident had not received her pain medication which was regularly scheduled. Review of the admission record for Resident #1 revealed an admitted [DATE] with diagnosis to include chronic pain syndrome. Review of October 2024 physician orders for Resident #1 showed the resident had orders for Hydrocodone-Acetaminophen oral tablet 5-325 MG (Milligram), Give 1 tablet by mouth every 12 hours for chronic pain. Review of October 2024 Medication Administration Record (MAR) showed the resident received Hydrocodone twice daily. The review showed the medication was not given from 10/17/24 to 10/21/24. Review of progress notes for Resident #1 dated 10/19/24 - 10/21/24 showed, medications were not administered, or awaiting medications to be delivered from another facility. A progress note dated 10/19/24 showed the Patient is unreliable historian. Nursing reports patient needs new prescription for her pain medication, which she takes regularly. 2. Resident #2 was admitted to Facility B on 09/19/24 with diagnoses to include Parkinson's disease, Type 2 diabetes, chronic pain and unspecified dementia. (continued on next page)

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

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 10/21/24 at 3:05 p.m., an interview was conducted with Staff A, RN. She stated Resident #2 did not have his medications. She said, He did not receive his Aspirin 81 MG for prophylaxis, and he did not get his pain patch. He does not have any narcotics available. He is supposed to receive Lorazepam for anxiety. He does not have any and I don't know where the medications are. Staff A stated this resident had displayed anxiety. She said, It could be storm related or just the whole move. Staff A stated she had not discussed the problem with the DON. She said, I was just about to. Review of October 2024 MAR and Physician orders showed the resident received Asperflex Pain Relieving Patch daily. The review showed the resident did not receive the pain patch. The review further showed the resident did not receive his Aspirin 81 MG. Review showed Lorazepam tablet 0.5 MG was ordered on 10/17/24 for anxiety. The record showed the resident had not received the medication yet. 3. On 10/21/24 at 3:08 p.m., an interview was conducted with Staff A, RN. She stated the nurse from the previous shift had reported Resident #3 had not received his insulin dose at 11:30 a.m. because the resident was out of the medication. Staff A, RN stated the physician had been notified and the insulin had been ordered. She stated they were waiting for delivery. Staff A stated she did not know if there was stock insulin that could have been administered. She stated she would check the inventory. Resident #3 was admitted to the receiving facility on 10/18/24 with diagnoses to include Type 2 Diabetes with diabetic neuropathy. On 10/21/24 at 3:10 p.m., an observation and interview was conducted with Resident #3. The resident said, I'm feeling fine now. I was a bit frustrated. I normally receive anywhere from 4 units to 8 units of insulin before meals. The nurse said I will get my insulin tonight. The resident stated the nurse did not test his blood sugar before lunch this day. The resident stated he had not received his insulin consistently while at this facility. Review of October 2024 MAR for Resident #3 showed there was no record of the resident's blood sugar check from 10/21/24 at 11:30 a.m. Review further showed insulin was not administered. The review showed on 10/19/24 and 10/20/21 the resident did not receive Donepezil HCl 5 MG for dementia. The documentation showed 9 was documented which means See progress notes. Review of progress notes revealed no documentation related to the dementia medication. Review of a progress note dated 10/19/24 showed Novolog Flex pan 100/unit/ML (milliliters) Medication on order, MD (Medical Doctor) aware. 4. On 10/21/24 at 3:30 p.m., an interview was conducted with Staff B, Licensed Practical Nurse (LPN). She stated she did not have narcotics for two of her residents (#5 and #4). She stated she had not administered any of their meds and to her knowledge, they had not had these medications all weekend. Staff B stated she did not have access to the facility's Emergency Drug Kit (EDK). Staff B stated Resident #4 and #5 had a scheduled narcotics but they did not bring the medications when they evacuated the residents from Facility C. Staff B stated [Resident #5] had an infection in his eye and she did not have eye drops for him. Review of Resident #4's admission record revealed an admitted [DATE] with diagnoses to include hereditary and idiopathic neuropathy, chronic peptic ulcer and other disorders of circulatory system. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of October 2024 MAR for Resident #4 showed the resident was prescribed Hydrocodone acetaminophen tablet 10-325 MG, Give 1 tablet by mouth every 4 hours for pain. The review showed this resident did not receive the medication from Friday, 10/18/24 through Monday 10/21/24. The documentation showed a 9 was entered, meaning see other/progress notes. Review of Resident #4's progress notes dated 10/18/24 - 10/21/24 showed medication was not available, with the following notes, still waiting for script, still waiting delivery. Review of Resident #5's admission record revealed an admitted [DATE] with diagnoses to include chronic kidney disease , stage 3B, Type 2 diabetes mellitus with diabetic neuropathy, and unspecified sleep disorder among others. Review of Resident #5's October 2024 MAR showed this resident did not receive scheduled medications. This included Modafinil 200 MG, give 200 mg in the morning for sleep disorder, Lyrica Oral capsule 25 MG (Pregabalin), Give 1 capsule by mouth two times a day related to Type 2 diabetes mellitus with diabetic neuropathy and did not receive Gatifloxacin Ophthalmic solution 0.5%, instill 1 drop in right eye four times a day for bacterial conjunctivitis for 7 days. A progress note dated 10/19/24 showed the medication was not available to be given. 5. Review of the admission record for Resident #6 showed the resident was admitted on [DATE] with a primary diagnosis of chronic respiratory failure. Review of the October MAR for Resident #6 showed the following medications were not administered as ordered: Eliquis 2.5 MG tablet, give 1 tablet by mouth twice a day for atrial Fibrillation. Documentation showed the medication was not administered from 10/18/24 to 10/20/24. Trazodone HCl Oral tablet, Give 1 tablet by mouth every morning related to major depressive disorder. Documentation showed the medication was not administered from 10/18/24 to 10/20/24. Benzonatate capsule 100 MG, Give 1 capsule by mouth three times a day for cough for 10 days. Documentation showed the medication was not administered from 10/18/24 to 10/21/24. Spironolactone tablet 100 MG, Give 1 tablet by mouth one time a day for leg edema. Documentation showed the medication was not administered from 10/18/24 to 10/20/24. Fluticasone SPR 50 MCG (microgram) 1 spray in nostril one time a day related to allergic rhinitis, unspecified. Documentation showed the medication was not administered from 10/18/24 to 10/21/24. Azelastine HCl 0.05 % solution, instill 1 drop in both eyes one time day for Ocular allergies. Documentation showed the medication was not administered from 10/18/24 to 10/21/24. Glycerin-Hypromellose-PEG, 400 Opthalmic solution 0.2 - 0.21%, instill 1 drop in both eyes once a day for dry eyes. Documentation showed the medication was not administered from 10/18/24 to 10/21/24. Symbicort inhalation Aerosol 80-4.5 MCG/ACT, 2 puffs inhale orally two times a day for SOB (Shortness of Breath). Documentation showed the medication was not administered from 10/18/24 to 10/21/24. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	6. On 10/21/24 at 3:38 p.m., an interview was conducted with Staff C, RN. Staff C stated her residents did not have the medications they needed. Staff C said, They did not anticipate these residents needs at all. They should have their medications here by now. It is not acceptable. Staff C stated she had notified the weekend supervisor from Facility A the residents did not have their medications. Staff C said, I notified [Staff D, RN/Weekend supervisor from Facility A] on Saturday. He had an attitude. Our hands were tied. Staff C stated Resident #7 did not have his anxiety medications and had been asking. She stated this resident was prescribed Clonazepam tablet 2 mg, one tablet by mouth every morning and bedtime for anxiety. Staff C said, That is just one of them. I have a resident in room [ROOM NUMBER] B, he has no medications at all. 7. On 10/21/24 at 3:56 p.m., an interview was conducted with Staff E, LPN. She stated one of her residents (#8) missed medications on Saturday (10/19/24) and Sunday (10/20/24) because the nurses could not access the Emergency Drug Kit (EDK). Staff E stated some of the medications were obtained from the kit, but some of them were still unavailable for example she said, [Residents #6, #9, #10] do not have a bunch of meds. Staff E stated she had notified Staff F, LPN/ Unit Manager (UM) on Friday the 18th when the residents arrived that they needed medications. She stated they did not receive any narcotics, inhalers, creams, ointments and eye drops. Staff E stated some of the medications could not be obtained from the EDK and they had requested new orders. Staff E provided a list of 6 residents who had missed their medications. Review of the admission record showed Resident #8 was admitted to the facility on [DATE] with a primary diagnosis of Alzheimer's disease with early onset. Review of Resident #8's October 2024 MAR showed some medications were not administered from 10/18/24 to 10/20/24. The medications included: Amlodipine Besylate oral tablet , give 5 MG by mouth once a day for HTN (Hypertension). Jardiance 25 MG, Give by mouth once a day for DM (Diabetes Mellitus), Losartan Potassium Oral Tablet 25 MG, give once a day for HTN (Hypertension) and Nystatin powder 100000 topical, apply to under breast and groin topically BID (Twice daily) for candidiasis cutaneous. 8. Review of the admission record showed Resident #9 was admitted to the facility on [DATE] with a primary diagnosis of Osteomyelitis, Right ankle and foot. Review of Resident #9's October 2024 MAR showed medications were not administered as follows: Gabapentin oral cap 100MG, Give 1 capsule every day for neuropathy on 10/18/24 and 10/19/24. Alprazolam Oral tablet 0.5 MG, give 0.5MG by mouth every 12 hours for anxiety was not administered on 10/18/24 and 10/19/24. Eliquis oral tablet 5MG was not documented as administered on 10/18/24. 9. Resident #10 was admitted to the facility on [DATE] with diagnoses to include unspecified dementia, end stage renal disease, Type 2 diabetes and low back pain. Review of Resident #10's October 2024 MAR showed orders to administer Oxycodone acetaminophen tablet 5-325 MG, give 1 tablet by mouth every 12 hours for pain. The record showed this medication was not administered from 10/17/24 to 10/21/24. The MAR further showed the resident did not receive Trazodone oral tablet, give 0.25MG two times a day for anxiety on 10/18/24-10/20/24 and Arnuity Ellipta 200 MCG/ACT aerosol powder, inhale 1 puff one time a day for COPD (Chronic Obstructive Pulmonary Disease) was not administered on 10/20/24 and 10/21/24. Progress notes for Resident #10 dated 10/18/24 - 10/20/24 showed the medications were on order and the MD had been notified. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	10. Review of a facility document provided by the Nursing Home Administrator (NHA) titled, Resident's missing medications showed: Resident #11 was missing Breo Ellipta 100-25 MG/ACT powder, Amiodarone HCl 200mg, Flonase 50 MCG, Glycerin-Hypromellose-PEG 400 Ophthalmic solution, Pantoprazole sodium 20 MG and Lisinopril 20MG. Resident #11 was admitted to the facility on [DATE] with a primary diagnosis of COPD. Resident #12 was missing Divalproex sodium 250MG and Lactulose 20 GM/30ML. The resident was admitted to the facility on [DATE] with a primary diagnosis of paranoid schizophrenia. Resident #13 was missing Tramadol HCL 50 MCG, give 50 MG by mouth every 12 hours as needed for pain breakthrough. The resident was admitted to the facility on [DATE] with a primary diagnosis of Atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs. Resident #14 was missing Rosuvastatin Calcium 5 MG, give 1 tablet by mouth one time a day for HDL (High Density Lipoprotein). The Resident was admitted to the facility on [DATE] with a primary diagnosis of post procedural retroperitoneal abscess. On 10/21/24 at 4:05 p.m., an interview was conducted with the Director of Nursing (DON), Facility B. The DON stated it was noted on Saturday 10/19/24 that something was wrong with the medications. She stated Staff D, RN from Facility A was coordinating the resident transfers. She stated corporate was notified the medications were missing and Staff D was sent to the previous location, Facility C to locate the medications. The DON stated the medications could not be located. She stated they had been working on obtaining new orders. On 10/21/24 at 4:11 p.m., an interview was conducted with Staff F, LPN Unit Manager Facility B. She stated she became aware this morning the residents had not been receiving their medications. She stated she was trying to obtain new scripts. She stated they were having problems obtaining the scripts because they did not have access to Facility A's profile and pharmacy information. Staff F stated the resident's narcotics were never received from Facility C. On 10/21/24 at 4:20 p.m., a telephone interview was conducted with Staff D, RN weekend supervisor Facility A. He stated the residents who were missing medications were their residents who evacuated from Facility A to Facility C and had now moved to Facility B. He stated he did not participate in the transfer process. He said, I became aware of the missing medications on Saturday. I drove to Facility C but could not locate the narcotics. I reported to my NHA that some of the residents did not have their medications. The NHA said to go to all the other facilities and find the medications. Staff D stated he could not locate the unaccounted medications including narcotics. On 10/21/24 at 4:41 p.m., a telephone interview was conducted with Staff G, Acting NHA from facility A. She stated the residents should all have their medication by now. She said, They called and reported the residents did not have their meds and I had the nurse practitioner write new orders. I thought this was all taken care of. Staff G Acting NHA stated she was notified on Saturday 10/19/24 there were problems with medications availability. She said, It should have been resolved. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 10/21/24 at 4:49 p.m. with Facility B's NHA. He stated they had received 34 residents who were originally from Facility A but had evacuated to Facility C. He stated he did not know there were medication concerns until this afternoon. He said, I did not know anything until you mentioned it. The DON is following up now. On 10/21/24 at 5:10 p.m. an interview was conducted with the Regional Nurse Consultant. The RNC stated she had been at the facility all morning and did not know there was a problem with medications. She stated no one had notified her, otherwise the issues would have been resolved. The RNC said, I was here when the residents from Facility A arrived to Facility B. I helped receive and reconcile all the medications that were received. The RNC stated the following morning Staff D, RN from Facility A was at Facility B ordering medications. The RNC stated the residents should not have missed their medications. She stated they could have been pulled from the Emergency Drug Kit. She stated they had most of the medications available if not all. The RNC stated all the nurses needed to do was to pull the medications from the EDK or notify her if they did not have access. On 10/21/24 at 7:23 p.m., an interview was conducted with The RNC, The NHA, The DON and the Regional [NAME] President. The RNC stated they had just audited all medication carts and ensured all medications that were unavailable were ordered STAT, meaning immediately. She stated any medications that were in the emergency medication storage would be accessed while awaiting supply to be delivered from the pharmacy. The DON stated she had started education for the nurses on accessing the emergency drugs. She stated the problem was that they did not have access, and they did not notify anyone. She said, Our nurses had a problem pulling medications for Residents from Facility A from Facility B's Emergency Drug Kit. She stated that was a system issue. The Regional VP stated they had not executed their emergency plan effectively if they could not pull emergency drugs to meet the resident's emergent needs. The NHA said, Now we know. Review of a facility policy titled, Physician Orders, Revised on 3/3/21 showed the center will ensure that physician orders are appropriately and timely documented in the medical record. The procedure showed for admission orders, 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. Confirmation of admission orders requires that the physician sign and date the order during or as soon as practicable after it is provided, to maintain an accurate medical record.