

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER Aspire at Tallahassee		STREET ADDRESS, CITY, STATE, ZIP CODE 3101 Ginger Dr Tallahassee, FL 32308	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48176</p> <p>Based on record review and interviews, the facility failed to maintain accurate and updated medical records for 1 out of 8 residents sampled. (Resident #2)</p> <p>The findings include:</p> <p>On [DATE], it was decided by the family that Resident #2's code status would be changed to Do Not Resuscitate (DNR). The family started the process and the facility assisted in getting the order signed by the doctor that same day. The Social Service Assistant brought back the completed to the facility at approximately 4:45 PM.</p> <p>On [DATE], Resident #2 was observed in bed without respirations and cold to the touch. Staff F, a Licensed Practical Nurse (LPN), and Staff G, a Registered Nurse (RN), confirmed the advance directive on the electronic medical record, and it stated Resident #2 was a Full Code. Per facilities policy, they had to double check the Advance Directives book, located at the nurse's station, but it was not there. Staff F and G started cardiopulmonary resuscitation (CPR) until paramedics pronounced the resident expired.</p> <p>On [DATE] at approximately 9:20 AM, during an interview with Regional Director of Clinical Services, she was asked what the expectation was regarding the location of the Advance Directives book. She stated the book should never leave the nurses' station. When asked who was responsible for updating the orders when the completed DNR was received, she stated nurses are the only ones that can change orders.</p> <p>On [DATE] at approximately 12:36 PM, an interview was held with Staff E, a LPN, who was the nurse the day Resident #2 had the change in advance directives. When asked how she found out about the DNR order, she stated the social services assistant came back and announced she had received it, and she had witnessed her adding it to the book. When asked if that was the appropriate process, she stated that, before it gets added to the book, a nurse must update the orders. When asked if she had received a request to update the orders, she said she had not. She also stated she would never change those orders until she could verify the form was correct and had all signatures.</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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NAME OF PROVIDER OR SUPPLIER Aspire at Tallahassee		STREET ADDRESS, CITY, STATE, ZIP CODE 3101 Ginger Dr Tallahassee, FL 32308	
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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>On [DATE] at approximately 1:09 PM, an interview was held with Staff H, the Social Services Assistant (SSA). When asked if she had handed one of the nurses the completed DNR form, she stated she had announced to Staff E that she had the form while walking by her. She then put the form in the advance directives book. When asked if Staff E saw the form and was able to read it, the SSA stated she did not think so. She was asked if she had requested that Staff E update the electronic record, she replied, no, but it was understood.</p> <p>The DNR was updated to the electronic medical record after Resident #2 had expired</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>48176</p> <p>Based on observation and interview, the facility failed to maintain an adequately equipped call light system for the 100 hall of the building.</p> <p>The findings include:</p> <p>During the initial tour of the facility, it was noted that all the residents in the 100 hall were observed with hand held bells located at the bedside of each resident. When asked about this, the Administrator stated that the call light system was not working and these bells were being used in lieu of the call lights for now. He stated the call light system had been broken in the 100 hall for a very long time.</p> <p>However, it was noted upon looking in the rooms that there was no system of calling staff located in each of the bedrooms' private bathrooms.</p> <p>Upon further discussion, the Administrator stated the parts for the call light system had recently arrived and the repairs to the system should occur soon.</p>		