

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Aspire at Ridge Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 4927 Voorhees Rd New Port Richey, FL 34653	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide Resident #17 had a dignified existence that included transportation to outpatient appointments. Findings include: On 5/31/2026 at 12:10 p.m., an observation was made of Resident #17 in her room. Resident #17 stated a recent event at the facility in which she fractured her leg, went to the hospital for treatment (a non-operative approach) and a knee immobilizer was the best treatment plan. Resident #17 lifted her blanket to the side to show a knee immobilizer in place. Resident #17 stated she knew she was supposed to see the orthopedic surgeon for a follow up but stated no one has updated her on when the appointment would be. Resident #17 stated she had an appointment at the end of last year (2025) to see a rheumatologist to rule out a potential diagnosis of Lupus (Systemic Lupus Erythematosus). Resident #17 stated she on multiple occasions the facility had arranged an appointment to see a rheumatologist but each time the appointment was cancelled because of her weight. Resident #17 stated she herself called her insurance company the last time her appointment was cancelled and was told next time she would have to go in a boxed unit vehicle. Resident #17 stated her symptoms have included hot spots on her upper extremities as well as a red butterfly appearance across her face. A review of Resident #17's admission Record showed an original admit date of 9/23/2024 with a readmission date of 4/23/2026 and diagnoses to include but not limited to: Broken internal left knee prosthesis, subsequent encounter Displaced bicondylar fracture of left tibia, subsequent encounter for closed fracture with routine healing Chronic respiratory failure with hypoxia Chronic Obstructive Pulmonary Disease Morbid (severe) obesity due to excess calories Rheumatoid arthritis without rheumatoid factor, unspecified site A record review of Resident #17's Minimum Data Set (MDS) dated Mar (March) 30, 2026, showed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #17 is cognitively intact. A record review of Resident #17's progress note on 12/29/2025 at 16:11 p.m. (Military time for 4:11 p.m.) showed the following: Appointment with Dr. [Name of Rheumatologist], with the address in [NAME], including the physician office phone number on 12/29/25 @ 10:30 a.m. Pick up will be 9:15-9:45 a.m. Transport through [commercial transport service] phone number. Confirmation number. refused to go to appt, authored by Staff E, Licensed Practical Nurse (LPN). A record review was conducted in the electronic medical record for Resident #17 and no further follow up appointment for a rheumatologist was documented. On 6/03/2026 at 9:40 a.m., an interview was conducted with Staff E, LPN who stated she remembered the resident's appointment but could not state if the resident ever had her appointment rescheduled. Staff E, LPN stated if she had a resident with an appointment, either a prescription or from the discharged hospital, she would place the order in the resident's electronic medical records. Staff E, LPN stated Staff I, Certified Nursing Assistant (CNA)/Transportation/Appointments will locate a physician, obtain approval through the insurance (continued on next page)		

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	company and arrange transportation. Staff E, LPN stated Staff I, CNA would notify the nurses under orders when the arrangements have been made. On 6/03/2026 at 9:40 a.m., an interview was conducted with Staff C, LPN. Staff C, LPN stated she is the Unit Manager for the assigned hallway for Resident #17. Staff C, LPN/UM reviewed Resident #17's medical record and confirmed the last appointment/order for Resident #17 for a rheumatologist was 12/29/2025. Staff C, LPN/UM stated she recalled her wheelchair was too wide to fit into the transport vehicle. Staff C, LPN/UM stated physical therapy assisted at one point to transport Resident #17 into a narrower wheelchair to accommodate transport to her appointments, but she was too uncomfortable. On 6/03/2026 at 10:06 a.m., an interview was conducted with Staff I, CNA. Staff I, CNA confirmed he is responsible for arranging appointments and transportation for the facility. Staff I, CNA stated he has made multiple arrangements for Resident #17, but each time transportation would show up to transport her to the appointment(s), accommodations could not be met due to the size (width) of her wheelchair. Staff I, CNA stated at one point the facility tried a stretcher for transport of Resident #17 but the lift to the transport van could not lift the stretcher up to enter the van. Staff, I CNA stated the facility's van had recently been repaired but stated it could not accommodate her transport needs. Staff I, CNA stated he does not know what a box transport means. Upon further interview, Staff I, CNA stated he did not schedule anymore due to her refusing and disheartening and embarrassed attitude. Staff I, CNA stated every time transportation was arranged, the service did not have what she needed to accommodate her transport safely. Staff I, CNA stated he did not know what to do other than arrange transport through an ambulance service. Staff I, CNA stated he had mentioned the transport issues to her primary physician. Staff I, CNA stated the facility does not have a rheumatologist come to their facility and the closest one he could locate for Resident #17 was in another city. Staff I, CNA confirmed therapy got involved to assist her with her transport but with no success. Staff I, CNA stated it was not her weight but the width of her lower pelvic area. Staff I, CNA stated the referral should still be good and he will investigate ambulance service for transport. On 6/03/2026 at 10:29 a.m., an interview was conducted with the Advanced Nurse Practitioner (ARNP) for Resident #17's primary physician. The ARNP stated she thinks the appointment to see a rheumatologist was resident driven. The ARNP stated she did not recall conversations with her primary physician in which a rheumatologist was recommended. The ARNP stated she would follow-up with the primary physician and if Resident #17 wants to see a rheumatologist she would make sure it happens. On 6/03/2026 at 11:03 a.m., an interview was conducted with Resident #17 in her room. Resident #17 was in her wheelchair with her immobilizer in place to her left lower extremity. Resident #17 stated it was her primary physician who had referred her to a rheumatologist, not her request. She stated no one had ever gotten back with her after her last attempted appointment at the end of December. Resident #17 stated she did not refuse her appointment. Resident #17 stated on the day of her appointment she was ready to go but the transport van showed up, brought her to the van and stated the van could not accommodate her. She stated a second transport service came an hour later with the same result. She stated a third attempt was offered but she stated by then she would have for sure missed her appointment. Resident #17 stated, since then no further appointments have been offered and she feels sad about the situation. Resident #17 stated she fractured her leg a month ago and she knows she has to have a follow up appointment with the orthopedic surgeon in six weeks post fracture but again no one has gotten back with her on when the appointment has been made and it has already been 4 weeks. Resident #17 stated she is currently non-weight bearing but after the follow-up appointment is hopeful she can start physical therapy. A review of Resident #17's hospital Discharge summary, dated [DATE], showed the following:Non weightbearing to the affected extremity for 6 weeks and use of a (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	well-padded knee immobilizer. Follow up with Dr. [physician name], Orthopedic surgery within 3-5 days. On 6/03/2026 at 5:04 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated they are in the process of planning for her appointment but was unaware of the orthopedic follow-up appointment. The DON stated arrangements for the orthopedic appointment will be arranged as well. A review of the facility's policy titled: Transportation, effective date 11/30/2014 showed the following policy statement: It is the policy of The Company to ensure residents access to medical services. Procedure: .2. When the resident has no personal resources, transportation will be arranged. This may be: a. Free transportation through social agency b. Taxi c. Medical transportation d. Ambulance e. Facility provided 3. The social service department will maintain a list of available medical transportation resources in the community		

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide reasonable access for phone communication for one (Resident # 28) out of eight residents sampled. Findings include: On 06/01/2026 at 10:00 AM Resident # 28 was observed at the nursing station on the phone discussing personal business around staff and other residents. She stated she doesn't like to make phone calls at the nurse's station because everyone hears her conversation and she doesn't have any privacy. On 06/02/2026 at 1:00 PM and at 4: 45 PM, Resident # 28 was observed lying down in bed. She stated she had told staff a few months ago that she wanted a phone in her room so she could receive and make phone calls. Review of an admission record dated 06/03/2026 showed Resident # 28 was readmitted [DATE] with diagnoses to include but not limited to metabolic encephalopathy, unspecified asthma, uncomplicated, chronic respiratory failure with hypoxia, and chronic obstructive pulmonary disease. On 06/02/2026 at 2:00 PM an interview was conducted with Staff E, License Practical Nurse [LPN]. Staff E stated she was aware Resident # 28's request for a phone, a while ago. Someone [facility staff], I don't remember who, told Resident #28 they were going to bring a phone, and they did. Although, the one they put in her room doesn't work. On 06/02/ 2026 at 2:30 PM an interview was conducted with the Maintenance Director. The Maintenance Director stated every resident should have a phone in their room. The only reason a phone would not be in a resident room is when there had been a request by the resident to remove the phone. Resident #28 was provided with a phone yesterday but the line in her room doesn't work. We have to call a professional phone company to install a phone line in her room. He stated prior to them putting a phone in her room yesterday he did not know how she received or made phone calls because the line in her room doesn't work. On 06/02/2026 at 3: 00 PM an interview was conducted with the Nursing Home Administrator[NHA]. The NHA stated all residents should have phone access in their rooms so they can call their family or friends. The facility can't restrict a resident's right to communicate with whoever they want in a private area. The Nursing Home Administrator stated the facility did not have a policy for this citation.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure Level 2 Preadmission Screening and Resident Review (PASRR) evaluation was submitted for one (Resident 88) out of five residents reviewed. Findings include: Review of an information record dated 06/03/2026 showed Resident # 88 was admitted to the facility originally on 04/22/2022 and readmitted on [DATE] with diagnoses to include but not limited to unspecified dementia without behavioral disturbance, recurrent moderate major depressive disorder, brief psychotic disorder, generalized anxiety disorder, and bipolar type schizoaffective disorder. Review of a PASRR dated 2/21/2024 revealed Resident # 88 had Anxiety Disorder, Depression Disorder, Psychotic Disorder, Schizoaffective Disorder and other schizoaffective disorder, bipolar type listed as qualifying mental health diagnoses. Review of the medical record revealed the resident was not assessed for PASRR Level II. On 06/03/2026 at 3:12 PM an interview was conducted with the Social Service Director [SSD]. The SSD stated that when a resident is admitted to the facility, she reviews their PASRR. If the PASRR is incorrect, they are updated, then signed by a Registered Nurse. During the review of the PASRR if they become aware of any conditions put on the third page. For instance, if a resident had a [NAME] Act, or an altercation involving law enforcement or life limitation, then she would submit for level II PASRR. The SSD stated when Resident # 88 arrived at the facility she did not have most of the diagnoses that were added to her chart. Resident #88 had a fall with fracture, and she was having nightmares that her husband was sleeping around with residents at the facility. At that time Resident #88 was reassessed and her level I PASRR was updated with new diagnoses. The SSD stated they did not submit for level II because Resident #88 had a short-term mental episode, but she returned back to her baseline. Review of the facility policy titled Policies and Procedures Revision date 11/08/2021 showed Subject: Preadmission Screening and Resident Review (PASRR). Policy: The center will assure that all Serious Mentally Ill (SMI) and Intellectually Disable (ID) residents receive appropriate pre-admission screening 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. Procedure: 4. If it is learned after admission that a PASRR Level II screening is indicated, it will be the responsibility of Social Services to coordinate and/or inform the appropriate agency to conduct the screening and obtain the results.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility did not review and revise the comprehensive care plan related to communication for one (Resident #49) of five residents reviewed for care plans. Findings include: Review of Resident #49's admission record revealed an admission date of [DATE], with an initial admission date of [DATE]. Diagnosis to include but not limited to malignant neoplasm of head, face, and neck (onset [DATE]), and other specified types of non-[NAME] Lymphoma, lymph nodes of head, face, and neck (onset [DATE]). Review of Resident #49's Minimum Data Set Resident Assessment (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 14, indicating intact cognitive function. Hearing aid or other hearing appliances used is marked no. Review of Resident #49's care plan revealed a focus to include a potential communication problem due to: hard of hearing. Review of Resident #49's Audiology Treatment Note dated [DATE] revealed Resident #49, a long-standing hearing aid user, was fitted for hearing aids. Treatment note dated [DATE] revealed the resident is doing very well with the hearing aids but would like an increase in volume for voices. On [DATE] at 3:25 p.m., Resident #49 stated he wears hearing aids, but his hearing aids were not working. He stated the batteries died and he has been unable to charge them. He stated he has let staff know about his hearing aids, but they have not been fixed. On [DATE] at 1:13 p.m., during an interview with Staff H, Certified Nursing Assistant (CNA), stated Resident #49 wears hearing aids. She stated she was unaware of Resident #49 having issues with his hearing aids. She stated she would look at a kardex to determine if they wear hearing aids. On [DATE] at 1:22 p.m., during an interview with Staff G, Registered Nurse (RN), stated Resident #49 wears hearing aids, and was unaware he had issues with them. She stated she looks at the resident's care plan to determine if they wear hearing aids. On [DATE] at 10:33 a.m., an interview was conducted with the MDS coordinator. She stated care plans are updated when there are new physician orders, new diagnosis, or if there are updates to the resident's health record. She stated Resident #49 has a communication problem but is not care planned for hearing aids. She stated if Resident #49 wears hearing aids, there should be a care plan for hearing aids. On [DATE] at 10:45 a.m., an interview was conducted with the Social Services Director (SSD). She stated Resident #49 has hearing aids but does not always wear them. She stated she was aware Resident #49 was having issues with his hearing aids and has placed him on a list to be seen by the Audiologist. She stated if a resident has hearing aids, it should be on their care plan. On [DATE] at 1:46 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated since she does not care for the resident personally, she is unaware if he has hearing aids. She stated if the resident has hearing aids, it should be on their care plan. Review of the facility's policy titled Plan of Care, with an effective date of [DATE], revealed: Policy: 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. Procedure: Review, update, and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of OBRA MDS assessment (except discharge assessments), and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental, and psychosocial well-being.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observations, interviews and record review, the facility failed to provide bedfast and residents who prefer to be in their room receive activities to meet the interests and support the physical, mental and psychosocial well-being for one (Resident #82) of two resident reviewed. Findings included: On 5/31/26 at 3:35 p.m., an observation and interview occurred with Resident #82 and three of their family members. Resident #82's family members stated they have not seen staff engaging the Resident #82 in 1:1 activities during their stay at the facility. The family members stated they would prefer the facility to do more activities of Resident #82's preference and 1:1. The family members stated they did not mind if activities occurred while they are visiting as they prefer Resident #82 receive interaction that could stimulate, engage and potentially distract from certain behaviors. The family members stated Resident #82 loves to listen and sing to their favorite musician. The family stated they have only seen staff provide the activity one time during Resident #82's stay. On 6/1/26 at 9:32 a.m., 2:52 p.m., and 4:27 p.m.; Resident #82 was observed sleeping in bed. On 6/1/26 at 12:15 p.m., an interview was conducted with Staff J, Licensed Practical Nurse (LPN). Staff J, LPN stated they are unsure of what 1:1 activities are provided for residents who prefer to stay in their room or are bed bound. On 6/1/26 at 4:48 p.m., an interview was conducted with Staff F, Registered Nurse (RN). Staff F, RN stated they never see Resident #82 participate in activities, but Resident #82 used to often. Staff F, RN stated due to Resident #82's decline in health and worsening dementia it has been more difficult getting Resident #82 out of their room or bed to participate in group activities, and Resident #82 just doesn't want to get up anymore. On 6/2/26 at 3:26 p.m., an interview was conducted with Staff K, Certified Nursing Assistant (CNA)/Activities Assistant (AA). Staff K, CNA/AA stated the activity department records 1:1 activities and attendance in an activity binder. The department provides activities such as social talk or assisting the residents with whatever they may need help with. Staff K, CNA/AA stated Resident #82 loves participating in coffee social, and the resident is usually sitting at the nurses' station. Staff K, CNA/AA stated all activities are provided to all residents who attend. Attendance is documented, this includes 1:1s. Staff K, CNA/AA stated the Activity Director (AD) is the one who documents the residents' activities in the resident portal under the activity task. On 6/2/26 at 3:33 p.m., an interview was conducted with the AD. The AD stated 1:1 activities for bed bound or residents who prefer to remain in their room include social visits. The AD stated they document attendance and refusals in the activity attendance book. The AD stated they encourage residents to participate in activities as much as possible, but most times residents do not want to participate. The AD stated the CNA staff does not get the residents up and ready or bring them to activities as they have been requested to various times by the AD. The AD stated Resident #82 usually comes to the coffee social and will usually sit and sing to herself or make fun noises. The AD stated Resident #82's attendance in activities is documented daily in the participation record. On 6/2/26 at 4:37 p.m., the AD provided Resident #82's attendance record for the day 6/1/26. The residents' attendance was recorded for 9:45 a.m., coffee social; 10:30 a.m., Trivia; 1:30 p.m., Pretty Nails; and 3:00 p.m., TV Classics. On 6/3/26 at 9:45 a.m., an observation and interview was made with Resident #82. When asked to see Resident #82's nails, the resident presented their hands. The resident's nails were observed unpainted, a brown/black matter under the resident's nails, and untrimmed. Resident #82 stated they did not go to get their nails done on 6/1/26. Resident #82 stated they love having their nails painted and done and would like them to be done. On 6/3/26 at 10:13 a.m., an interview and observation was conducted with the Regional Nurse Consultant (RNC) with Resident #82 in the resident's room. The RNC stated Resident #82 is confused and might (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not know what day it is to determine if they went to activities on 6/1/26. Resident #82 told the RNC they did not get their nails done on 6/1/26 and the RNC confirmed the resident's nails were not done. Resident #82 told the RNC they love having their nails done and painted. On 6/3/26 at 1:55 p.m., an interview was conducted with the AD. The AD stated Resident #82 did not stay in the Pretty Nails activity due to being sent back to their room for being moody and disruptive. The AD stated Resident #82 typically does not refuse to participate in activities. The AD is unsure as to why there is a lack of Resident #82's attendance record for activities. The AD stated the activities department is responsible for ensuring activity attendance is documented, but they were gone for 3-weeks and just got back. The AD stated they do not track or document resident activity refusals. The AD stated most days Resident #82 is sleeping in bed and not at activities during the scheduled times. The AD stated they make adjustments to residents' care plans when interests change. On 6/3/26 at 3:43 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated residents should be offered and provided activities that meet their preferences. The DON stated there should be a wide range of activities for all residents, and activities to meet residents' cognitive levels. The DON stated activities have gotten better in variety but still are not very popular at the facility amongst the residents. The DON stated both care and activity staff should be encouraging residents to participate and providing residents with activity reminders. The DON stated the AD should be documenting and keeping track of attendance, and that all resident attendance and refusals should be tracked and documented in the resident's electronic health record (EHR). The DON stated for residents who cannot get out of bed or prefer to remain in their room should be offered 1:1 activities, and socializing is the bare minimum as a provided activity for this demographic of residents. The DON stated these residents should be offered stimulating 1:1 activities such as puzzles, games, coloring, and word searches. The DON stated Resident #82's attendance for activities should not be marked as attended if the resident had to leave the activity due to their behaviors, and it is not appropriate documentation if the resident is marked as attended if they did not get to participate in the activity. The DON stated Resident #82 tends to get bullied by other residents for making noises and singing, causing the resident to typically be removed from the activity. The DON stated based off the documentation, Resident #82 is not getting their preferred activities. The DON stated despite the resident's care plan being updated on 5/7/26, BINGO is still on their care plan for preferences of activity and should have been updated with the AD knowing the resident no longer likes the activity. A review of Resident #82's admission record revealed an initial admission date of 1/27/26 and a readmission date of 5/21/26, with diagnoses to include unspecified dementia, generalized anxiety disorder, mood disorder, major depressive disorder, altered mental status, and chronic kidney disease. A review of Resident #82's Quarterly Minimum Data Set (MDS) assessment, dated 2/3/26, revealed Resident #82 is cognitively intact. Further review of Resident #82's cognitive patterns revealed the resident scored a 2- no cue required for recall, and did not present any behaviors of inattention, disorganized thinking, and altered level of consciousness. Review of Resident #82's assessment of hearing, speech, and vision revealed the resident had adequate hearing and vision and is able to be verbally understood and understands others. For Resident #82's activity and routine preferences, the resident indicated the following: having books or magazines to read, listen to music they like, and participate in their favorite activities. Review of Resident #82's functional abilities revealed the resident has no impairments. A review of Resident #82's current Care Plan revealed staff is to invite, encourage and escort the resident to preferred activities consistent with the resident's interests as a diversion from pain related to general age discomfort. Further review revealed Resident #82's preferred recreational interests, as of 1/29/26, are listening to classical music, playing bingo, crocheting and reading (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mystery novelsA review of Resident #82's progress notes revealed there was no documentation regarding activities participation of any type being provided to the Resident #82.A review of Resident #82's activities attendance records from 1/1/26-6/3/26 revealed the resident has attendance and activities documented for the following dates:1/28/26: BINGO2/3/26: Indoor visits and fudge (activities goes room to room)2/8/26: Ice cream social3/3/26: Ice cream social3/25/26: Mini Luncheon4/2/26: Coffee Social4/8/26: Coffee Social4/9/26: Church Service4/28/26: The Price is Right5/2/26: Coffee Social5/27/26: Coffee Social, Mass with Father Joseph6/1/26: Coffee Social, Trivia, Pretty Nails, TV ClassicsResident #82 did not have any documented attendance for 1:1 activities.A review of Resident #82's Activities Task revealed the resident had no attendance or activities documented for at least the last 30 days for all 3 sections: Activity Location, Participated (Yes/No), Describe Activity.A review of the facility's Social Activities Policy, dated 11/30/14 and revised 3/13/19, revealed the following: The social activities are modified to meet the basic needs of love and belonging in residents who experience deficits in judgement, reasoning and perception. The activities focus on acceptance of the individual and the stimulation of learned social responses. To provide opportunities for socialization regardless of one's cognitive limitations. To provide an atmosphere of acceptance through strategic groupings of residents. To encourage the development of friendships.		

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NAME OF PROVIDER OR SUPPLIER Aspire at Ridge Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 4927 Voorhees Rd New Port Richey, FL 34653	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record review the facility failed to ensure timely care and physician notification related to a skin condition change for one (Resident #82) out of one resident sampled; and failed to provide medications as ordered for one (Resident #96) out of eight residents sampled. Findings included: On 5/31/26 at 2:15 p.m., an observation was made of Resident #82 lying in their bed aggressively itching their body. On 5/31/26 at 3:35 p.m., an observation and interview occurred with Resident #82 and three of their family members. Resident #82 was observed with random spots of a brownish color, on the resident's clothing, bed sheets, and pillow. Resident #82 was observed itching arms and legs continuously. Resident #82's family member stated the resident has been dealing with a severe rash for about three weeks and is unable to stop itching. The family members stated they have been asking for help for Resident #82. The family members stated they would like to find a cause or reason for the rash, rather than just treating its symptoms. Resident #82 was observed with severe redness of the skin and scattered bumps and open scarring from itching on the resident's back, stomach, and both full upper and lower extremities. On 5/31/26 at 3:47 p.m., Staff F, Registered Nurse (RN) changed Resident #82's shirt per the family members request. Staff F, RN stated they will put in a higher dosage of the resident's medication to subdue the itching and irritation of the skin. Staff F, RN stated they advised the Unit Manager (UM) of Resident #82 needing a dermatology consult. On 5/31/26 at 3:55 p.m., Staff J, Licensed Practical Nurse (LPN) came and provided Resident #82 with prescribed itching cream on all irritated areas. On 5/31/26 at 4:52 p.m., an interview was conducted with Staff J, LPN. Staff stated the resident has been dealing with this skin rash for at least a few days now. On 6/1/26 at 10:19 a.m., an interview was conducted with Staff L, Wound Care (WC)/LPN. Staff L, WC/LPN stated being unaware of Resident #82's skin condition but will check it out. On 6/1/26 at 4:27 p.m., an observation was made of Resident #82 sleeping in bed. Resident #82 was observed with the same shirt that was put on the resident on 5/31/26 with scattered brownish colored spotting present on the shirt and bed sheets. On 6/2/26 at 12:15 p.m., an interview was conducted with Staff J, LPN. Staff J, LPN stated they are unaware of Resident #82's shirt not being changed since 5/31/26. On 6/2/26 at 12:19 p.m., an interview was conducted with Staff L, WC/LPN. Staff L, WC/LPN stated they were informed of Resident #82's current skin condition and told the staff to seek a dermatology consult and advise the Medical Director (MD) about the situation. Staff L, WC/LPN stated they would (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expect residents' who have skin openings to have their wounds cleaned per the provider's order and to be in clean clothes each day. Staff L, WC/LPN stated it is not proper to leave a resident in the same blood stained clothing from the day before if the skin is open and bleeding. On 6/2/26 at 4:48 p.m., an interview was conducted with Staff F, RN. Staff F, RN stated Resident #82 started having these skin issues around 5/25-26/26. Staff F, RN stated they informed the UM of Resident #82 needing a dermatology consult on 5/31 around 4:00 p.m., Staff F, RN did not follow up with the UM on 6/1/26 due to being on the medication cart all day. During the interview an observation was made when Staff F, RN got up to ask Staff M, LPN/UM if they put in the consultation for dermatology for Resident #82. Staff M, LPN/UM was heard stating they did not put in the consultation for Resident #82. Staff F, RN returned and stated Resident #82 did not have the dermatology consultation entered. On 6/3/26 at 9:37 a.m., an interview was conducted with the Administrator of the Dermatology provider (ADP) for the facility. The ADP stated when they receive a consult, they will determine if the matter is urgent or not. If the skin issue present is an urgent matter, then one of the three dermatology providers will get to the facility within 24 hours. The ADP described a highly urgent skin issue as a rash causing the resident to suffer or causing the resident to be uncomfortable. The ADP stated consults can be received over the phone or through fax. The ADP stated they have not received a dermatology referral from the facility for Resident #82 but are always willing to help if they were to receive. The ADP stated due to Resident #82's situation, it is expected for a dermatology consult be put in for the resident as it is an urgent matter and the resident's skin should have a scraping done to rule out what is going on with the resident. On 6/3/26 at 9:50 a.m., an observation and interview were conducted with Resident #82. Resident #82 was observed scratching uncontrollably and explaining they are just so itchy, and would like for something to be done to help the itching as they feel they are suffering. On 6/3/26 at 10:00 a.m., an interview and observation were conducted with the Director of Nursing (DON) and the Nursing Home Administrator (NHA). The DON stated Resident #82's rash is present all over their body and advised the resident they should not keep itching and digging at their skin. Resident #82 stated they are unable to help the itching as it is awful and does not stop. Resident #82 told the DON and NHA they would love something to be done. The DON stated at least the MD should have been notified as this being an urgent issue a dermatology consult should have been put in right away for Resident #82. The DON stated the care staff did not follow proper protocol when a resident has a change in condition (CIC) and should have advised the proper parties to start a treatment plan. A review of Resident #82's admission record revealed an initial admission date of 1/27/26 and a readmission date of 5/21/26, with diagnoses to include dementia, anxiety disorder, mood disorder, major depressive disorder, altered mental status, and chronic kidney disease. A review of Resident #82's Quarterly Minimum Data Set (MDS) assessment, dated 2/3/26, revealed Resident #82 is cognitively intact. Resident #82's cognitive patterns revealed the resident did not need a cue required for recall, and did not present any behaviors of inattention, disorganized thinking, and altered level of consciousness. Review of Resident #82's assessment of hearing, speech, and (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vision revealed the resident had adequate hearing and vision and can be verbally understood and understand others. Review of Resident #82's functional abilities revealed the resident has no impairments. Review of Resident #82's skin conditions revealed the resident is at risk of further or worsening skin issues but no current skin issues. A review of Resident #82's current Care Plan revealed the resident is at risk for skin breakdown and should have daily skin observations for any signs and symptoms of skin breakdown. Review of Resident #82's chart did not reveal any CIC completed related to skin rashes. A review of Resident #82's progress notes dated 5/4/26-6/4/26 revealed a physician note from 5/31/26 and 6/2/26 stating staff had not reported any significant physical changes in Resident #82's condition. A review of Resident #82's Weekly Skin Evaluations from 5/10/26-6/3/26 revealed the following: 5/11/26: No new areas of concern. 5/17/26: No new skin issues noted at this time. 5/27/26: No new skin issues noted at this time. 6/3/26: No other skin issues noted staples removed from head on 5/31 A review of Resident #82's Skin Observation Task from 5/5/26-6/4/26 the resident was observed with a red area of skin on the following dates: 5/5/26, 5/8/26, 5/9/26, 5/10/26, 5/12/26, 5/15/26, 5/16/26, 5/22/26, 5/23/26, 5/26/26, 5/27/26, 5/30/26, 5/31/26, 6/1/26, 6/3/26. The red area was reported to be a new skin condition on the following dates: 5/23/26, 5/26/26, and 6/1/26. A review of the facility's Notification of CIC Policy, dated 11/30/14 and revised 12/16/20, revealed the following: The center is to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is a change in the status or condition. Procedure: The nurse to notify the attending physician and Resident Representative when there is a(n): Significant change in the patient/resident's physical, mental, or psychosocial status Need to alter treatment significantly New treatment Discontinuation of a current treatment due to but not limited to: Adverse consequences Acute condition (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Exacerbation of a chronic condition . The nurse to complete an evaluation of the Patient/Resident. Document evaluation in the medical record. Notify the patient/resident and the resident representative of the CIC. Document notification in the medical record. Document resident/patient CIC on 24 hour report. Photographic evidence obtained. 2. On 6/2/26 at 4:00 p.m., Resident #96 was observed sitting up in his wheelchair visiting with his resident representative (RR). Resident #96 was observed well-groomed with no signs of distress. The RR stated having some concerns. The RR stated Resident #96 had orders for medication related to an eye infection and did not receive it until seven days after the doctor ordered the medication. The RR stated Resident #96 was supposed to receive the medication on May 18th and did not receive any medication for his eye until the 25th of May. Review of a Resident Information Record dated 6/3/26 showed Resident #96 was admitted to the facility on [DATE], with diagnoses to include but not limited to Parkinson's Disease without dyskinesia, without mention of fluctuations, Type 2 Diabetes Mellitus with hyperglycemia, vascular dementia. Review of an Electronic Medication Administration Record [EMAR] showed Bacitracin Ophthalmic Ointment 500 Unit Gram (Bacitracin Ophthalmic) instill 1 application in left eye two times a day for 7 days until 5/25/26. Order start date 5/18/26. Review of an Administration note dated 5/19/26 Bacitracin Ophthalmic Ointment 500 Unit Gram instill 1 application in left eye two times a day for 7 days until 5/25/26, showed, on order. Review of an Administration note dated 5/20/26 Bacitracin Ophthalmic Ointment 500 Unit Gram instill 1 application in left eye two times a day for 7 days until 5/25/26, showed, waiting for pharmacy to send. Review of an Administration note dated 5/22/26 Bacitracin Ophthalmic Ointment 500 Unit Gram instill 1 application in left eye two times a day for 7 days until 5/25/26, showed on order. Review of an Administration note dated 5/25/26 Bacitracin Ophthalmic Ointment 500 Unit Gram instill 1 application in left eye two times a day for 7 days until 5/25/26, showed, call placed to hospice to change medication per pharmacy requires an alternative. Review of an Administration note dated 5/25/26 Erythromycin Ophthalmic Ointment 5 Milligram/ Gram instill 1 application in left eye two times a day to apply to left eye for hordeolum twice daily for 7 days. Until 6/2/26. Ordered. On 6/2/26 at 5:28 p.m. an interview was conducted with Staff G, LPN. Staff G stated Resident #96 (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was ordered Bacitracin for 7 days for a Sty on the left eye. The medication was ordered on May 18th, but the facility never received the medication. Someone documented that they gave Resident #96 the Bacitracin, but she knows that it was not administered because reached out to the pharmacy and the medication never arrived, as the pharmacy did not have the medication. Staff G, LPN stated informing the nurse practitioner and the medication was changed to Erythromycin and provided to Resident #96 on May 26th. On 6/2/26 at 5:49 p.m. an interview was conducted with a [Pharmacy Provider (PP)] Pharmacy Tech/Customer service representative. The pharmacy tech stated the pharmacy received an order from the facility on May 18th for Bacitracin 500 grams. The medication was identified as an over-the-counter drug. They received a new order for Erythromycin that was delivered to the facility on the 26th. The pharmacy tech stated she have to transfer the call to her supervisor to provide more information as to why the Bacitracin medication was not delivered to the facility when the pharmacy received the order. On 6/2/26 at 6:00 p.m. an interview was conducted with the [PP] Customer Service Lead. The Customer service lead stated they received an order for Bacitracin 500 grams for 7 days from the facility. They faxed an authorization form to the facility on 5/20 for coverage because the medication was identified as an over-counter drug. Based on review, the facility did not send the authorization back to the pharmacy to cover the cost of the drug. On 6/3/26 1:31 p.m. an interview was conducted with the Director of Nurses [DON]. The DON stated she was informed about Resident #96 Bacitracin this morning or yesterday afternoon. She stated she should have been informed about the situation when it happened. When the nurses were informed that the medication was not available, they should have reached out to the physician to obtain another script so that the resident could have received his medication. Review of the facility policy titled, Administering Medication Revised dated April 2019. Showed Policy Statement, Medication are administered in a safe and timely manner, and as prescribed.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure that nebulizer supplies was stored according to professional standards for one (Resident #28) out of eight residents sampled. Finding include: On 06/01/2026 at 10:00 AM, and on 06/02/2026 at 4:47 PM Resident #28's nebulizer mask was observed lying down exposed, unbagged on top of the nightstand. Review of an admission record dated 06/03/2026 showed Resident #28 was admitted originally on 08/20/2020 and readmitted [DATE] with diagnoses to include but not limited to metabolic encephalopathy, asthma, chronic respiratory failure with hypoxia, and chronic obstructive pulmonary disease. On 06/02/2026 at 4:47 PM an interview was conducted with Staff E, License Practical Nurse, [LPN]. Staff E stated the nebulizer mask was supposed to be stored in a bag and not left out on the nightstand. She stated she will throw the mask away because she doesn't know how long the mask has been sitting on the nightstand. She stated she knows she did not put the mask on the nightstand because she has not given Resident #28 the nebulizer treatment yesterday nor today. On 06/03/2026 1:41 PM an interview was conducted with the Director of Nurses [DON]. The DON stated the expectation is all medication should be given as ordered. Nebulizer masks should be stored in a bag when not in use and the bags are dated when the bag is changed, typically weekly. Review of the facility policy titled, Equipment Change Schedule Revision date 08/28/2017 showed policy: An equipment changes schedule providers a schedule for change disposable equipment ay regular intervals as determined by manufacturer's recommendations and standards of practice. Procedure: Equipment/ When changed. Nebulizer set-up: Once, every seven (7) days along with equipment bag labeled with name, date, and room number.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews and record reviews, the facility failed to ensure the medication error rate was less than 5.00%. Thirty-two medication administration opportunities were observed and four errors were identified for two (Resident #4, and 23) out of six residents observed. These errors constituted a 12.5% medication error rate. Findings include: On 6/02/2026 at 8:55 a.m., an observation was made during medication administration for Resident #23. Staff E, Licensed Practical Nurse (LPN) pulled the following medication: Folic Acid 800 micrograms one tablet from the medication cart's over the counter drawer designated over the counter drawer and administered the medication to Resident #23. A record review of Resident #23's physician orders showed an order dated 4/28/2026 for Folic acid one milligram to give one tablet by mouth in the morning for supplement. On 6/02/2026 at 10:01 a.m., an observation was made during medication administration for Resident #4. Staff F, Registered Nurse (RN) pulled the following medications: Methocarbamol 75 milligrams (mg), one tablet Oxycodone HCL (hydrochloride) 20 mg one tablet Gabapentin 600 mg one tablet A record review of Resident #4's physician orders showed an order for the following: Methocarbamol oral tablet 75 mg, give one tablet by mouth every 6 hours as needed for muscle spasms, ordered 5/08/2026 Oxycodone HCL 20 mg, give one tablet by mouth every 4 hours as needed for non-acute pain, ordered 5/202/2026 Gabapentin 600 mg, give one tablet by mouth every 8 hours for neuropathy, ordered 5/13/2026 Upon review of the Medication Administration Record (MAR) for the month of June 2026, Resident #4's Gabapentin was due at 8:00 a.m. but was administered 10:01 a.m. Upon review of the MAR for the month of June 2026, documentation for both the Methocarbamol and the Oxycodone were not documented as administered to Resident #4. On 6/03/2026 at 5:04 p.m., an interview was conducted with the Director of Nursing (DON) and the Regional Nurse Consultant (RNC). Both were notified of the erroneous concerns post medication administration. A review of the facility's policy titled: Administering Medications, revised April 2019 showed the following policy statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation include but not limited to: 4. Medications are administered in accordance with prescriber orders, including any required time frame. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. 22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.		

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a Compliance and Ethics Program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure accurate documentation related to medication administration for two Residents (#28, #96) out of eight residents sampled. Findings include: 1Review of an admission record dated 06/03/2026 showed Resident # 28 was admitted originally on 08/20/2020 and readmitted [DATE] with diagnoses to include but not limited to metabolic encephalopathy, unspecified asthma, uncomplicated, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, unspecified Review of an Electronic Medication Administration Record showed Ipratropium- Albuterol Solution 0.5-2.5 (3) milligrams/3 milliliters [MG/ML], 3 inhales orally via nebulizer three times a day for Chronic Obstructive Pulmonary Disease [COPD] 05/12/2026, revealed medication was marked administered at 1500 on 06/01/2026. On 06/02/2026 at 4:47 PM an interview was conducted with Staff E, Licensed Practical Nurse [LPN]. Staff E stated she works 7 am to 7 pm. She stated she did not give Resident # 28 her nebulizer treatment on 6/1 because the resident was in activities. 2Review of a Resident Information Record dated 06/03/2026 showed Resident # 96 was admitted to the facility on [DATE], with diagnoses to include but not limited to Parkinson's Disease without dyskinesia, without mention of fluctuations, Type 2 Diabetes Mellitus with hyperglycemia, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance mood disturbance, and anxiety. Review of an Electronic Medication Administration Record [EMAR] showed Bacitracin Ophthalmic Ointment 500 Unit Gram (Bacitracin Ophthalmic) instill 1 application in left eye two times a day for twice daily for 7 days until 05/25/2026. Order start date 05/18/2026. [EMAR] showed medication was administered on 05/18/2026 at 1700 and on 05/20/2026 to 05/22/2026 at 0900. Review of an Administration note dated 05/19/2026 and 5/22/2026 Bacitracin Ophthalmic Ointment 500 Unit Gram instill 1 application in left eye two times a day for twice daily for 7 days until 05/25/2026, showed medication was on order. Review of an Administration note dated 05/20/2026 Bacitracin Ophthalmic Ointment 500 Unit Gram instill 1 application in left eye two times a day for twice daily for 7 days until 05/25/2026, showed awaiting for pharmacy to send. On 06/02/2026 at 5:28 PM an interview was conducted with Staff G, License Practical Nurse [LPN]. Staff G stated Resident # 96 was ordered Bacitracin for 7 days for a Sty on his left eye. The medication was ordered on May 18th, but it never arrived at the facility. Someone documented that they gave Resident # 96 the Bacitracin, but she knows that it was not administered because she informed the nurse practitioner and reached out to pharmacy that the medication never arrived to the facility. They ended up having to order a different medication for him. On 06/03/2026 1:31 PM an interview was conducted with the Director of Nurses [DON]. The DON stated her expectation is that her nurses document according to policy and not falsely document in the medical record. The facility said the did not have a documentation policy for this citation.		