STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105440	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Colonial Lakes	15204 W Colonial Dr Winter Garden, FL 34787

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on interview, and record review, the facility failed to appropriately document, investigate, follow up, and promptly resolve grievances for 1 of 3 sampled residents, (#1). Findings: Resident #1 was initially admitted to the facility on [DATE] with diagnoses that included type II diabetes, chronic kidney disease stage III, major depressive disorder, vascular dementia with agitation, hemiplegia/hemiparesis following stroke affecting the right dominant side, and persistent mood disorder. The Quarterly Minimum Data Set assessment dated [DATE] revealed resident #1 had a Brief Interview of Mental Status score of 5 out of 15 which indicated severely impaired cognition. The assessment revealed she required substantial to maximum assistance for toileting, dressing, and personal hygiene. On 12/4/24 at 12:35 PM, a telephone interview with resident #1's daughter confirmed that she was the Power of Attorney (POA) and visited her mother daily. She said that she had been having issues with her mother's missing items for about six months but she was unsure of the exact date. She said that about six months earlier, her mother's dentures went missing when a staff member accidentally threw them away. She was told by the previous Administrator and Social Service Director (SSD) that they would work on replacing them. She said she did not hear anything else regarding the dentures until recently when the new SSD started working at the facility and told her that they were working on getting a new dentist for her mother. She explained that in October 2024 she had complained to staff because when her mother was moved to a different room, per her request, all her mother's belongings went missing. She reported that the facility lost her clothing, shoes, cellphone, and glasses. These items were listed on her mother's inventory sheet, and she was the one responsible for doing her mother's laundry. She said that she spoke with the facility Administrator, Assistant Administrator, SSD, and Business Office Manager (BOM) but nothing was done, and they did not offer to reimburse her for the lost items. She said that she was unsure if a grievance was ever filed for the missing items. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility Grievance log from June 2024 to November 2024 revealed that a grievance had been filed on 9/19/24 for resident #1's missing dentures. The investigation had been assigned to the Administrator but there was no resolution indicated. There were no other grievances found for resident #1 during that time period. Further review revealed that from June 2024 to November 2024 there were 155 grievances filed, with 9 unresolved, and 83 that were either not assigned to a staff member to investigate or not properly documented with a resolution and complainant notification date. There were 22 grievances related to missing items included. On 12/04/24 at 12:21 PM, the SSD confirmed she was the Grievance Officer and had started working in the facility in October 2024. She noticed that there were grievances dating back to July 2024 that had not been investigated or resolved by the previous SSD. She met with the current Administrator, previous SSD, and Regional SSD regarding the unresolved grievances and let them know that her plan would be to start with the unresolved grievances since September 2024. She explained that when a grievance was received from a resident either verbally or in writing, the staff member receiving the grievance would complete a grievance form and submit to the Grievance Officer. Then she would assign a department leader to investigate, resolve, follow up with the resident, and have them sign acknowledging the resolution was to their satisfaction. When a resident reported a missing item, the staff member receiving the grievance would attempt to find the item first and then if still not found the grievance was given to the SSD to be assigned for further investigation. She said that when items were not found they would replace or reimburse the resident. The SSD said that she was aware that resident #1's representative had reported the dentures were missing in June of 2024 but was unsure why the grievance had not been filed until September 2024. She confirmed that there were no grievances filed for resident #1's missing clothing, cellphone, shoes, or glasses. On 12/04/24 at 1:04 PM, the Social Service Assistant (SSA) said that she had been working at the facility since July 2024. She confirmed that based on the facility's grievance policy, grievances had to be resolved within seven days of receipt and not exceed 14 days. She said that one of the issues that prevented timely resolution of grievances was that when they were assigned to the department leaders for investigation, they would often return the forms to Social Services with no resolution or notification to the resident. On 12/05/24 at 12:31 PM, the Resident Council President confirmed that several grievances had been filed regarding missing items. She said that she had not received a resolution for the grievances and the facility did not follow up with her regarding the status of the grievances. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/05/24 at 4:15 PM, the facility Administrator confirmed that he was made aware by the SSD, shortly after being hired in September 2024, that there were grievances that had not been resolved since July 2024. He said that the issue had been discussed at the Quality Assurance and Performance Improvement (QAPI) meeting on 11/14/24, which was attended by the Administrator, Director of Nursing, Medical Director, SSD, and Assistant Administrator. The plan was to audit and review grievances that had been outstanding prior to the new team, review the grievances with the resident or representative, and to ensure the resolution was acceptable. The SSD, Administrator, and all departments would work together to audit and resolve the outstanding grievances. He said that the goal was for all outstanding grievances to be resolved by the end of the year and to ensure that new grievances were handled in a timely manner. When asked for audits or documentation to show the work that had been done from 11/14/24 to present, he said that they had no documentation to show what had been done. He confirmed that resident #1's missing items had been reported to him around October 2024 by the resident's representative, but he did not complete a grievance form. He said that the facility looked for the items but did not find them and he had not followed up with the resident's representative regarding a reimbursement for the items. He said that the expectation was for grievances to be documented, investigated, and resolved in a timely manner. Review of the Complaint/Grievance Policies and Procedures revised 10/24/22, revealed that the center would make prompt efforts to resolve the complaint/grievance and inform the resident of progress towards resolution. The grievance procedures stated the following: an employee receiving a complaint/grievance from a resident, family member or visitor would initiate a Complaint/Grievance Form, the Grievance Officer or designee shall act on the grievance and begin follow-up of the concern or submit it to the appropriate department director for follow up, the grievance follow up should be completed in a reasonable time frame, which should not exceed 14 days, and the individual voicing the grievance would receive follow up communication with the resolution, and a copy of the grievance resolution would be provided to the resident upon request.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on interview, and record review, the facility failed to maintain medical records that were complete and accurately documented in accordance with professional standards of practice for 1 of 3 sampled residents, (#1). Findings: Resident #1 was readmitted to the facility on [DATE] from an acute care hospital with new diagnoses that included urinary tract infection (UTI), need for assistance with personal care, and muscle weakness. She also had a past medical history of type II diabetes, chronic kidney disease stage III, major depressive disorder, vascular dementia with agitation, and persistent mood disorder. The Quarterly Minimum Data Set assessment dated [DATE] revealed that resident #1 had a Brief Interview of Mental Status score of 5 out of 15 which indicated she was severely cognitively impaired. The assessment revealed she required substantial to maximum assistance for toileting, dressing, and personal hygiene. On 12/04/24 at 12:35 PM, in a telephone interview, resident #1's daughter confirmed at she was the Power of Attorney (POA) for her mother. She said that she noticed her mother's functional abilities started to decline in October 2024 and she required more assistance with activities of daily living. She said that on 11/04/24 she had visited the facility and noticed that her mother was not acting like herself. She reported her mother's condition to the nurse and was told that they would notify the doctor. On 11/05/24 she visited resident #1 again and requested for her to be transferred to the emergency room (ER) because she had vomited and was lethargic. Resident #1 was transferred to the ER, but she felt that her mother had not been assessed appropriately, so she requested to see progress notes from 10/23/24 to 11/03/24. She said that the facility provided her the progress notes but they contained no care notes documenting her mother's change of condition. She said there were several notes regarding refusal of care by her mother. She confirmed that at the hospital they diagnosed resident #1 with a urinary tract infection and she was ordered antibiotics. Review of resident #1's daily progress notes revealed that on 10/23/24 she was seen by the doctor and there were no changes reported. The next entry starts on 10/29/24 with several notes that reported she refused medications and glucose monitoring. The daughter and Nurse Practitioner were notified of the refusals on 10/29/24. On 10/30/24 there was a single note entry at 5:34 AM, which documented that the resident refused glucose monitoring. There were no entries on 11/04/24 to indicate that staff assessed resident #1 after the daughter expressed concern with her altered mental status and medication refusals. On 11/05/24 at 4:46 AM, there was a note that documented that resident #1 refused lab work that was ordered due to lethargy. On the same day at 11:59 AM, there was a change of condition note for altered mental status and an order for resident to be transferred to the hospital per the daughter's request. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/24 at 12:59 PM, Registered Nurse (RN A) said that she documented any changes from baseline for the resident, such as changes in mood, behavior, or mental status. She would assess, report and document the changes even if it was reported by the family member. On 12/05/24 at 3:20 PM, the Director of Nursing (DON) stated that nurses were expected to document by exception meaning that any changes in condition or change from baseline would be documented in the resident's medical record. She said that she was not aware that resident #1's daughter had reported a change with her mother on 11/04/24. On 12/05/24 at 3:45 PM, the Medical Director stated that on 11/04/24 resident #1 was seen by the Physician Assistant (PA) after a staff member reported that she was lethargic, and labs were ordered to rule out a UTI. He stated that on 11/05/24 he ordered for the resident to be transferred to the ER by request of the daughter. The DON was present during the interview and stated that if the nurse identified a change in the resident's condition on 11/04/24, it should have been documented. Review of the facility's policies and procedure for Medical Records, revised 8/25/17, revealed that the policy required clinical records to be maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care. It stated that the purpose of the clinical record was to document the course of the resident's plan of care and to provide a medium of communication among health care professionals involved in the care. The policy indicated the clinical record should include a record of the resident's assessments, the plan of care and services, and progress notes which indicated a change toward achieving the care plan objectives.