STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105445	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at University Hills	10040 Hillview Road Pensacola, FL 32514

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28603 Based on observations, staff interview, and policy review, the facility failed to provide housekeeping and maintenance services neccessary to maintain a sanitary and orderly interior for 11 of 32 sampled rooms and 2 common areas observed. (Rooms 106, 110, 123, 129, 131, 208, 226, 227, 228, 232, 234, the unit one hallway, and the locked unit day room) The findings include: During a tour of the locked memory care unit with the Administrator and Employee B (Regional Maintenance Director) on 9/18/24 at 3:58 PM, the following was observed: room [ROOM NUMBER]B had blinds in disrepair. room [ROOM NUMBER] had a dark stain on the bathroom floor and an unlabeled wash basin on the back of the toilet. room [ROOM NUMBER] had two fire dampers bulging from the ceiling tile near the door. room [ROOM NUMBER] had one door that was missing from the armoire. room [ROOM NUMBER] had no curtains or blinds on the window and had a partially patched hole in the wall. The locked unit day room had a cove base missing from the wall near the exit door. Photographic evidence was obtained of all of the above. During the tour, the Administrator stated the former Maintenance Director was supposed to audit the blinds last week and she was not sure if this happened. She stated the brown stain in room [ROOM NUMBER] looked like rust and the basin should be labeled and stored in the resident's cabinet. She was not sure why the cove base was removed in the day room of the locked unit or why the door was missing from the armoire in room [ROOM NUMBER]. The Administrator confirmed the wall was not fully repaired in room [ROOM NUMBER]. 30584 (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER] On 09/17/24 at 4:17 PM, an observation of the privacy curtain in room [ROOM NUMBER] revealed several dark brownish/[NAME] spots on the curtain. Interview with the two residents living in this room revealed the curtain has always been stained like this since they each arrived in this room. On 09/18/24 at 9:11 AM and 12:29 PM, follow up observations of the privacy curtain in room [ROOM NUMBER] revealed it to be the same stained/soiled curtain. (photographic evidence obtained) 50082 During a tour of the 100 hallway on 9/17/24 at approximately 12:30 PM, the following issues were observed: room [ROOM NUMBER]'s mini blinds on the window were broken and twisted, not allowing for total privacy from the outside. room [ROOM NUMBER]'s mini blinds were broken with paper taped to the glass to cover the area not covered by the blinds. room [ROOM NUMBER] had 2 large gashes in the drywall on the wall nearest the bathroom door. On 09/18/24 at approximately 4:26 PM, during a tour with the Regional Maintenance Director and the Executive Director (ED), the ED acknowledged the environmental deficiencies in rooms 129, 131 and 123. 50783 room [ROOM NUMBER] During an observation of room [ROOM NUMBER] on 09/16/24 at 11:13 AM, there was noted a black colored film in the ceiling area. The bathroom towel rack and glove box holder were observed to have raised flaky and rusted areas across the bar. The ceiling tiles were noted with a dark grey dust on them. There were broken blinds in the room window with a privacy curtain tacked across the window. The dresser sitting by the B bed has the bottom drawer missing. The safety floor mat was observed to be dirty and torn. (photographic evidence obtained) room [ROOM NUMBER] During an observation of room [ROOM NUMBER] on 09/16/24 at 11:20 PM, dark green and blackish circular spots were noted on the ceiling tiles of the doorway. Brownish color areas observed beind the entry door. (photographic evidence obtained) Unit One During an observation of the unit one hallway on 9/16/23 at approximately 11:00 AM, there was observed multiple areas in the ceiling tiles with greenish and black colored spots. (photographic evidence obtained) (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy for Maintenance (effective 11/30/14) revealed the facility's physical plant and equipment will be maintained through a program of preventitive maintenance and prompt action to identify areas/items in need of repair.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50783 Based upon interviews, observations, and record reviews the facility failed to implement the care plan to meet the nursing and physical needs to maintain the highest functional well-beingfor 1 of 22 residents reviewed for care plans. (Resident #95) The findings include: On 09/16/24 at approximately 01:30 PM Resident #95 was observed attempting to feed herself with her family present. Despite repeated attempts, she was unsuccessful using silverware and used her hands to feed herself, dropping much of the food in the process. On 09/17/24 at 12:36 PM, the resident was observed laying in bed with a bedside tray table positioned next to the bed with a lunch tray positioned on it with tray positioned at chin level. Resident #95 was observed having difficulty feeding herself. Resident #95's milk was not opened and Resident #95 was observed unsuccessfully attempting to open it. Resident #95 was observed with food debris down the front of her clothing and on her chin where she attempted to feed herself. On 09/18/24 at approximately 08:45 AM, Resident #95 was observed sitting up in bed with breakfast tray sitting on bedside table. Resident #95 had a towel placed on her chest area for protection but food debris was observed on the front side of her shirt. A staff member entered room to pick up meal trays. I asked the staff member who identified herself as a CNA but did not give her name if the resident required any assistance with eating her breakfast this morning. The staff member responded no, she feeds herself and left the room carrying the breakfast tray to the dietary cart. Resident #95's brother was interviewed on 9/16/24 concerning this issue. He stated, They don't always come in here and check on her. They keep her curtain pulled and can't see her if she is having trouble swallowing or starts to choke on her food. He stated he had spoke to the Administrator about this and he was assured it would be addressed, but he cannot see that it has been corrected for the past three weeks. The grievance log showed a grievance was written on 09/04/24 regarding Resident #95 not being assisted with meals. The grievance submitted on 9/4/24 indicated that the facility would initiate therapy to screen resident for speech therapy. The Director of Nursing (DON) would review the care plan and update as needed. Staff would be educated on the resident's status for eating meals. Resident #95's physician order states that she has a dietary order for a regular, no added salt diet with Dysphagia Advanced texture, Regular with Thin Liquids consistency, Chopped Meats and fortified foods and Milk with meals. A physician's order dated 4/8/24 stated the resident was to be up in her wheelchair for all meals. An order dated 9/5/24 also states that Resident #95 is to be assisted for meals and to cue resident and assist with feeding with every meal. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record review states that Resident #95 is care planned for the potential nutritional problems related to hemiparesis / hemiplegia hindering her ability to feed herself. This care plan was initiated on 4/15/23. Current interventions include monitor and document any signs of dysphagia, pocketing, choking, coughing, drooling, or holding food in her mouth. Resident will be provided a divided plate and adaptive equipment / utensil with each meal. On 6/19/2024, a care plan was initiated for Resident #95, who is at high risk for aspiration related to swallowing assessment results. Current interventions include: all staff is to be informed of residents dietary and safety needs. Resident is to alternate small bites of food and small sips of fluid, use a teaspoon for eating, do not use straws. Staff is to check mouth after meal for pocketed food and debris. Resident #95's Minimum Data Set (MDS) assessment on 3/27/24 states the resident requires set up and clean up assistance for eating, oral hygiene, partial to moderate assistance for toileting, shower/ bathing, dressing, and personal hygiene, and transfers. The MDS assessment on 5/20/24 reveals she needs partial / moderate assistance required for eating, oral hygiene, dressing, and transfers. dependent assistance for toileting and bathing. A MDS assessment dated [DATE] stated the resident did not have a swallowing disorder or an issue with loss of liquids from mouth when eating or drinking or an issue with holding food in mouth/cheek. On 9/17/24 at approximately 02:00 PM, during an interview with CNA staff N, she stated she cares for Resident #95 consistently and is familiar with Resident #95's care needs. When asked about where the resident eats her meals, CNA N responds Mostly in her room, she will refuse to get up out of bed. When asked how much assistance the resident needs with eating meals, CNA N responds she doesn't need to be assisted with meals. When asked if the resident requires any special equipment to eat or requires to be queued to eat her meals or feed herself, CNA N responds that the resident doesn't have any special adaptive equipment and does not need to be queued to eat her meals. CNA N stated the resident usually eats about 40-50% of her meals. CNA N stated the only time she refused to eat was when she was on a puree diet. When CNA N was asked if Resident #95 has lost any weight, she responded, I don't see any difference in her weight. The DON was interviewed on 09/17/24 at approximately 04:15 PM about Resident #95. She was asked why the resident does not have any weights documented for the months of June, July, and August 2024. The DON stated that she did not know but did state that the resident will refuse to be weighed at times. The DON also acknowledged, per physician orders, that a CNA or any staff member had to be present for all mealtimes. That clinical staff is to stay with resident while Resident #95 is eating to assist as needed and cue resident to eat her meals. On 9/18/24 at approximately 11:58 AM, an interview was conducted with the DON and Administrator regarding the grievance initiated for Resident #95 on 09/04/24.The Administrator and DON agreed that the resident was care planned and has a physician order to be assisted with meals. When asked why, on three separate observations, Resident #95 was feeding herself and no staff member present during mealtimes, the DON responded that there should be a staff member present during meals. They agreed that she uses a divided plate and built up utensils so the food won't slide off the plate. When asked why she had not been using specialized equipment during the observations, the Administrator stated that she did not know but she will follow up with dietary regarding the adaptive equipment as it is their responsibility to insure that the correct plate and adaptive equipment is sent on the meal trays.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 48580 Based on observations, interviews, and review of the electronic medical records (EMR), the facility failed to provide necessary range of motion services for 1 of 4 residents sampled for range of motion. (Resident #68) The findings include: A review of Resident #68's medical record revealed an order dated 4/03/2024 stating Resident up to wheelchair every meal, every shift. Further review of the EMR revealed that staff had signed off on Resident #68 being up in her wheelchair for meals on 9/16/2024, 9/17/2024 (evening and night shift), 9/18/2024 and 9/19/2024 (day shift). However, on four separate observations on 09/16/24 at approximately 11:56 AM and 03:10 PM and on 09/17/2024 at approximately 08:35 AM and 03:59 PM, Resident #68 was observed to be in her bed. On 09/17/24 at approximately 12:45 PM, Resident #68 was observed semi-reclined in bed, leaning to the right side. The lunch tray was delivered by Staff Member P, a certified nursing assistant (CNA), who proceeded to reposition the resident and began to feed resident #68 her lunch. An interview was conducted with Staff Member P, who indicated that fluids were offered with meals and medications but that the resident is unable to request or drink on her own. When asked if the resident is put in her wheelchair, CNA P responded No, she can't sit in that because she is too stiff, we can't put her legs up. She slides forward, she's too stiff. On 09/17/2024, a telephone interview was conducted with Resident #68's daughter, who stated that the resident has never been observed to be out of bed on her visits. She stated that her visits occur primarily on weekends or after work. On 09/18/24 at approximately 09:35 AM, an interview was conducted with Staff Member O, Registered Nurse (RN), who indicated Resident #68 is fully dependent for care. She acknowledged that the resident has not been getting out of bed for every meal and that this has been something that has needed to be updated.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 50082 Based on staff interviews, record review, and the facilities' policy and procedures, the facility failed to maintain ongoing communication and collaboration with the dialysis center regarding dialysis care and services for 1 of 1 residents reviewed for dialysis care. (Resident #43) The findings include: A review of Resident #43's dialysis communication binder on 9/19/2024 revealed the last dialysis communication form was completed on 8/9/2024, even though Resident #43 had been receiving dialysis care from an outside facility every Monday, Wednesday, and Friday. On 09/18/24 at approximately 11:47 AM, the director of nursing (DON) indicated the residents have their own dialysis binders that are used to communicate with the dialysis center which should be kept at the nurses' station. The unit managers check the dialysis binders weekly to ensure the dialysis communication sheets are being completed. A concurrent interview with Staff C, unit manager, confirmed she did not follow up on these. On 09/18/24 at approximately 02:23 PM, during a follow-up interview with the DON, she stated that the expectation is that the 11:00 pm-7:00 am shift nurse was to initiate the communication sheet and place it in the dialysis communication binder that is sent with the resident to the dialysis center. The dialysis center is then asked to communicate a summary of the residents' dialysis treatment. The facility nurse receiving the resident then reviews and acknowledges the communication from dialysis to ensure continuum of care. If the dialysis center does not complete their portion, it is the facilities responsibility to fax it to or contact the dialysis center by phone and get the communication of care. The DON acknowledged the last communication between the facility and the dialysis center was on 8/9/24. A review of the facilities policy and procedure named Coordination of hemodialysis services, N-1359 effective 11/30/2014, revised 07/02/2019 (page 1 of 1) states residents requiring an outside ESRD facility will have services coordinated by the facility. There will be communication between the facility and the ESRD facility regarding the resident. the facility will establish a dialysis agreement/arrangement if there are any residents requiring dialysis services. the agreement shall include how the residents care is managed. 1) the dialysis communication form will be initiated by the facility for any resident going to an ESRD center for hemodialysis. 2) Nursing will collect and complete the information regarding the resident to send to the ESRD center. 3)The ESRD facility is to review the dialysis communication form and either: a) complete the communication form and return with the resident OR b) provide treatment information to the facility. 4) upon the residents return to the facility, nursing will review the dialysis communication for and information completed by the dialysis center OR the information sent by the dialysis center; communicate with the residents physician and other ancillary department as needed, implement interventions as appropriate. 5) Nursing will complete the post dialysis information on the dialysis communication form and file the completed form in the residents clinical record.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50082 Based upon record review and interviews, the facility failed to provide scheduled medications for 1 of 20 residents reviewed for medication administration. (Resident #43) The findings include: A review of the medication administration record (MAR) for September 2024 revealed Resident #43 has not been receiving the following medications at 9:00 AM and 1:00 PM on Mondays, Wednesdays, and Fridays, as he is out of the facility at dialysis during those times, resulting in multiple missed doses: 1. Prostat (a protein supplement to aide in wound healing) 2. Vit D-Cholecalciferol Oral Capsule 50 MCG (2000 UT) Give 1 capsule by mouth one time a day for supplement 3. Ciclopirox External Solution 8 % (Ciclopirox) Apply to fingernails topically one time a day (to treat fungal infection of the nail bed) 4. Clopidogrel Bisulfate Oral Tablet 75 MG (Clopidogrel Bisulfate) Give 1 tablet by mouth one time a day (an antiplatelet drug to prevent blood clots) 5. Clotrimazole Mouth/Throat Troche 10 MG (Clotrimazole) Give 1 lozenge by mouth one time a day for mouth (a medication to treat fungal infections) 6. Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG Give 0.5 tablet by mouth one time a day (a medication used to treat heart failure) 7. [NAME]-Vite Oral Tablet Give 1 tablet by mouth one time a day (a multivitamin for dialysis patients) 8. Apixaban Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day (a medication used for patients with atrial fibrillation to reduce the risk of stroke and blood clots) 9. Calcium Carbonate Oral Tablet Chewable 500 MG (Calcium Carbonate (Antacid) 10. Nepro 8oz. two times a day (a protein supplement for patient with End Stage Renal Disease (ESRD)) 11. Midodrine HCl Oral Tablet 5 MG Give 2 tablet by mouth three times a day (a medication used to treat low blood pressure) 12. Gabapentin Oral Capsule 100 MG Give 1 capsule by mouth three times a day (a medication used to treat pain) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/24 at approximately 10:08 AM, Staff I, a licensed practical nurse (LPN), stated anything that is on the MAR to give at 9:00 AM, I put LOA (Leave of Absence) because [Resident #43] is out of the building at dialysis. A review of the medical record revealed Resident #43 has a diagnosis of END STAGE RENAL DISEASE DEPENDENT ON RENAL DIALYSIS, ABNORMAL WEIGHT LOSS, AND PROTEIN-CALORIE MALNUTRITION. Resident #43 has a physician's order for Hemodialysis: Monday, Wednesday, and Friday starting at 7:30 AM. Resident #43 has a care plan for hemodialysis related to renal failure. The quarterly minimum data set (MDS), dated [DATE], reveals Resident #43 receives dialysis. On 09/18/24 at approximately 12:16 PM, an interview was conducted with the family nurse practioner (FNP-C) for Resident #43. He indicated the expectation is that the resident going to dialysis would be getting their medications before they leave the facility. He stated he has not been notified by the facility and was not aware until now that the resident has not been receiving all the medications that are scheduled at 9:00 AM. He stated that the resident should be getting these medications. The expectation is that the facility nurse would notify him if a medication is not able to be given for any reason. On 09/19/24 at approximately 11:48 AM, the DON, she indicates that she was not aware the resident was not receiving 9:00 AM scheduled medications 3 times per week on dialysis days. She stated the expectation is that the resident would have been receiving these medication before they leave for dialysis.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50447 Based on observations, staff interviews, review of the electronic medical record (EMR), and review of the facility policies and procedures, the facility failed to provide safe and secure storage of medications for 1 of 1 residents. (Resident #108) The findings include: On 9/16/24 at approximately 11:45 am, Resident #108 was observed with a Spiriva inhaler (a medication used to prevent wheezing and shortness of breath) positioned at bed side. Resident #108 indicated that the inhaler at bedside was empty; however, another inhaler was visibly stored in a nearby open drawer. On 9/17/24 at approximately 10:00 am, during an interview with Resident #108, he stated the Spiriva inhaler still remains in his drawer. A follow up observation at 2:35 pm verified the Spiriva inhaler was still in an open nightstand drawer. On 9/18/24 at approximately 11:30 am, during an interview with Staff C, a licensed practical nurse (LPN), she stated that the inhaler should not be there. LPN C indicated that she was unaware the Spiriva inhaler was in the resident's possession. On 9/18/24 at approximately 12:00 pm, the Assistant Director of Nursing (ADON) acknowledged Resident #108 does not have a physician's order to store or self-administer medications. A review of the medication administration record (MAR) reveals that Spiriva was administered as ordered. A review of the EMR for Resident #108 reveals no order for self-administration of medication. The care plan initiated on 6/27/24 does not include self-administration of medication. A review of the facilities Policy and Procedure: Medication and medication supply storage and disposal, Effective date: 11/30/2014 states, central storage of medications is required for prescription, prescribed over the counter medications and cam (complementary and alternative medicine). will kept in a locked area, in their original labeled container and may not be remove more than 2 hours prior to the schedule administration. Med will be kept in a medication cart that locks and keys are only accessible to the licensed personnel distributing medications.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28603 Based on observations and interviews, the facility failed to ensure the Resident Call lights were functional to allow residents to call for staff assistance for 1 of 32 rooms observed. (rooms [ROOM NUMBERS]) The findings include: room [ROOM NUMBER]: An observation of room [ROOM NUMBER] was conducted on 9/16/24 at 1:31 PM. The resident call system in the bathroom was not functional. A follow up observation of room [ROOM NUMBER] was conducted on 9/18/24 at 8:41 AM and the call system in the bathroom was still not functional. Employee L (Certified Nursing Assistant) confirmed the call system was not functioning. She stated the resident occupying the room toileted independently. Review of the facility policy for Communication Systems, Maintenance Inspection Testing and Safety (effective 11/30/14) revealed, .communication systems and components will be properly maintained to function reliably and ensure operator safety. In the event of systems or component failure the system operators will notify maintenance personnel. If maintenance is unable to resolve the problem the approved contractor will be notified.