STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105460	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at North Florida	6700 NW 10th Place Gainesville, FL 32605

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49444 Based on interview, record review, and review of policy and procedures, the facility failed to ensure the residents were free from medical neglect by failing to implement the policies and procedures for neglect for 1 (Resident #1) of 3 residents reviewed for insulin administration. On 10/6/2024 at 6:00 AM, Resident #1 had a blood sugar value of 552 and the on-call provider was notified of the value and the resident stated he was refusing medications until he received the proper insulin. Staff A, Licensed Practical Nurse, (LPN), did not communicate to Staff B, LPN or transcribe the new orders into the medical record for the increase in insulin and the addition of sliding scale insulin coverage. Staff B, LPN, assumed care of Resident #1 at 7:00 AM on 10/6/2024 and did not follow up with the provider. Staff B, LPN, did not reassess Resident #1's blood glucose or address the need for any orders. Resident #1 called 911 at approximately 6:30 PM, Emergency Medical Services (EMS) contacted the facility, spoke with Staff B, LPN, who instructed EMS the resident did not need help. Again at 11:15 PM, Resident #1 called 911 and was subsequently transferred to the hospital and was admitted to the Intensive Care Unit with a diagnosis of Diabetic Ketoacidosis. Diabetic ketoacidosis (DKA) develops when the body can't make enough insulin, a hormone that helps sugar enter cells for energy. Instead, fat is broken down for energy. This can cause acids called ketones to build up in the blood and collect in the urine. The risk is highest in people who have type 1 diabetes and those who often miss insulin doses. DKA symptoms often start quickly, sometimes within a day. A person may get very thirsty, urinate often, vomit or have stomach pain. Symptoms also can include tiredness or weakness, confusion, shortness of breath, or fruity breath. Treatment often involves going to a hospital to receive fluids, insulin and electrolytes through a vein. Without treatment, diabetic ketoacidosis can lead to loss of consciousness and death. (Mayo Clinic/Mayoclinic.org) The facility's failure to implement the policy and procedure for medical neglect and failure to ensure residents who required insulin administration received treatment in accordance with professional standards of practice led to a determination of Immediate Jeopardy at a scope and severity of isolated (J). The Nursing Home Administrator was notified of the Immediate Jeopardy on November 18, 2024, at 2:50 PM. The Immediate Jeopardy began on October 6, 2024, and was removed on site on November 18, 2024. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings include: Review of the Admission Record for Resident #1 documented an admitted [DATE] with diagnoses that include diabetes mellitus type 1, malignant neoplasm of oropharynx (cancer), unspecified dysphagia (unable to swallow), oropharyngeal phase, type 1 diabetes mellitus without complications, chronic pulmonary embolism (a blockage in a lung artery caused by a blood clot that has traveled from elsewhere in the body), chronic kidney disease, unspecified, other acute osteomyelitis (bone infection), unspecified site, acquired absence of left leg (below knee), essential primary hypertension (high blood pressure), gastrostomy status (a flexible tube that's surgically inserted into the stomach through the abdominal wall. It allows for the delivery of nutrition, fluids, and medication directly into the stomach), hyperlipidemia, unspecified (an abnormally high concentration of fats or lipids in the blood), peripheral vascular disease, unspecified (blood vessels narrow or become blocked, reducing blood flow to the limbs or other parts of the body). Review of the document titled Department of Internal Medicine Discharge Summary Heme/Onc [Hematology/Oncology] Team dated 10/3/2024 read: (page 1) Instructions for PCP [Primary Care Physician]: will need to keep an eye on his insulin regimen as these have been up and down since starting bolus tube feeds; currently on 12 units long acting and seven units short acting before bolus feeds. Consider endocrinology referral. (page 8) Discharge medication, mediation list documents Lantus Solostar 100/unit/ML [milliliter] Insulin glargine. Inject 10 units into the skin every 24 hours. Review of Resident #1's physician order dated 10/4/2024 read, Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 10 units subcutaneously one time a day related to Type 1 Diabetes Mellitus Without Complications. Review of Resident #1's Medication Administration Record (MAR) showed Staff A, LPN, documented a BS (blood sugar) of 552 on 10/6/2024 at 6:00 AM. Staff A, LPN, documented 2, CM (chart code/follow up codes 2 = drug refused). Review of Resident #1's eMAR (electronic Medication Administration Record) note dated 10/6/2024 at 6:32 AM documented by Staff A, LPN, read, Patient stated, I'm refusing all medications until I get the proper insulin. Review of Resident #1's progress note dated 10/6/2024 at 7:00 AM documented by Staff A, LPN, read, ARNP [Advanced Registered Nurse Practitioner] notified of resident's refusal of all morning medications. Per resident he is refusing all medications until he is receiving the proper insulin. Orders received to increase current insulin twice daily with blood sugars checked twice daily. No other orders given at this current time. Review of text message communication from Staff A, LPN's personal cellular phone to the On Call Medical Doctor (OCMD) on 10/6/2024 at 7:33 AM read, Good Morning, [Resident #1's name] is refusing all of his medications. He says he's not taking anything until he receives the proper insulin. Per his orders he's receiving 10 Units of Lantus @ [at] 6 am. He did allow me to check his blood sugar 552. Review of text message communication from the OCMD to Staff A, LPN's personal cellular phone on 10/6/2024 at 8:19 AM read, No sliding scale ordered? (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 8:22 AM read, No, I didn't see any sliding scale he said his Lantus is supposed to be given @ night. And he has another type of insulin he gets. I didn't see anything other than the Lantus. Review of text message communication from the OCMD to Staff A, LPN's personal cellular phone on 10/6/2024 at 10:55 AM read, Based on his sugars, if they have been above 250 everyday, go up to 15 BID [15 units two times a day] of long-acting insulin and make sure we cover with sliding scale for meals. Let's also make sure he's getting accuchecks. Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 7:55 PM read, I'll change his orders & notify him of the changes & hopefully he complies. Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 11:25 PM read, [Resident #1's last name] has continued to call 911 since I arrived this afternoon. They are loading him up & transporting him, [Resident #1's full name]. Review of Resident #1 medical record did not contain any documentation of the test message communication between the facility and the OCMD. Review of Resident #1's Interact SBAR (Situation, Background, Assessment, Recommendations) Communication form documented by Staff A, LPN, dated 10/6/2024 at 11:25 PM read, Situation: the change in condition (CIC) reported on this CIC evaluation are: other change in condition. At the time of evaluation patient vital signs, weight and blood sugar were blood pressure 130/77, pulse 82, temperature 98.2, pulse oximetry 96% on room air, blood glucose of 552 obtained at 6:45 AM on 10/06/24. Outcomes of physical assessment: positive findings reported were mental status evaluation with no change observed. Functional status evaluation with no changes observed. Patient called 911 on his personal cell phone and stated, I want out of this place. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: No new orders given at this time. Review of Resident #1's medical record did not contain any documentation of further blood glucose checks after the glucose level of 552 was documented at approximately 6:00 AM. Review of the hospital ED (Emergency Department) provider notes for Resident #1 dated 10/6/2024 at 11:51 PM read, Chief complaint: Patient presents with high blood sugar. Patient is an 81 y.o. [year old] M [male] with a PMH [Past Medical History] of oropharyngeal SCC [squamous cell cancer of throat], DVT [Deep Vein Thrombosis], PVD [Peripheral Vascular Disease], T1D [Type 1 Diabetes], HTN [Hypertension], and osteomyelitis who presents from an outside rehab after having unreadable glucose levels on his monitor. He states that at the outside rehab were not following his strict insulin regimen trying to give a different type of insulin. Per EMS [Emergency Medical Services] he was declining the insulin the outside rehab was trying to give him. He was recently admitted on ,d+[DATE] for pneumonia and was discharged to rehab NPO [nothing by mouth] with swallow study pending (gastrostomy tube in place). BASIC METABOLIC PANEL - Abnormal; Notable for the following components: Glucose 745, Anion Gap 34. Medical Evaluation Initiated: Attestation: The patient is critical due to DKA [Diabetic Ketoacidosis]. admitted to the ICU [Intensive Care Unit]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the hospital history and physical for Resident #1 dated 10/7/2024 read, HPI [history of presenting illness]: [Resident #1's name] is an 81 y.o. male presented with hyperglycemia at rehab admitted for DKA. PMH relevant for T1DM (Type 1 Diabetes Mellitus), HTN, oropharyngeal squamous cell carcinoma, peripheral vascular disease, DVT (04/2022) and below the knee amputation secondary to osteomyelitis. Patient reports lack of compliance with his long-term insulin regimen for DM1 [Type 1 Diabetes Mellitus] at his rehab facility. He reports they weren't giving me the right insulin and explains some of the doses of his regimen were being missed. During an interview on 11/13/2024 at 9:25 AM, the Director of Nursing (DON) stated, I was not here for the incident, I found out after I returned that Tuesday. That was the 8th [10/8/2024]. With a blood sugar that high the nurse should have notified the doctor that he [Resident #1] was refusing his insulin and why he was refusing it. The nurse in charge of his care was not acting within the professional standards of practice for treating hyperglycemia in a type 1 diabetic. He [Staff A, LPN] should have notified the doctor immediately when he [Resident #1] refused his insulin. He [Staff A, LPN] did not transcribe the orders, and he should have stayed and transcribed the orders he got. The nurse got the high blood sugar and spoke to someone. I don't know who he spoke with, I don't know their name, you will have to ask [the Administrator's name] and got new orders. I don't know if or what he told the nurse that came on in the day shift. I don't know what the day shift nurse did after that. This shouldn't have happened; this should have been avoided. The nurse that admitted him should have read everything when it comes to the discharge summary, and they would have seen all the other orders instead of just the one piece of paper. The blood sugar should have been rechecked. It was not rechecked the rest of the day. I would consider this neglect. I don't know why the abuse and neglect policies were not followed. We should have completed a RCA [root cause analysis] and we should have implemented the abuse policy and procedure back on the 7th [10/7/2024]. During a telephone interview on 11/13/2024 at 11:35 AM, the OCMD stated, I did receive a call related to this resident [Resident #1]. The Nurse called me on the afterhours line, and I was told of the residents' glucose and I actually decided to double the insulin, the Lantus, and increase it to 15 Units twice a day and to add SSIC [Sliding Scale Insulin Coverage] with insulin coverage AC [before meals] and HS [at bedtime]. I would say that the professional standard of practice would be to have the blood glucose rechecked after 30 minutes to one hour after high readings to accurately assess if the patient was stabilizing versus the patient needing further emergency treatment. The staff did not adhere to a professional standard of practice when they did not notify us that he was refusing treatment. I would expect staff to inform us that a patient had refused insulin to determine the next steps we needed to do, either increase medications or we send to the hospital. I would call this unintentional neglect. They did not treat this according to professional standards of practice. I should have been notified that the patient was refusing his insulin. I was not called about this again after I gave the orders to them. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/13/2024 at 3:18 PM, the Administrator stated, I found out about the situation when I returned to work. I was finally able to speak with the daughter on 10/20/2024. I didn't file a report on 10/7/2024 because we saw on the chart that they only had orders for Lantus, we didn't think it was an issue until he started refusing the medication. The report should have been done, that is the best practice. [Staff A, LPN's name] got the order. It was not placed in [name of the electronic medical record software]. We investigated and did a QAPI [Quality Assurance and Process Improvement] Ad hoc [from Latin meaning for this] meeting on 10/7/2024. I talked to [Staff B's name], she said that the resident refused medications and [Staff A's name] spoke to the nurse practitioner and got orders. The nurse forgot to transcribe the orders into [name of the electronic medical record software]. There was no documentation in [name of the electronic medical record software]. During an interview on 11/13/2024 at 3:43 PM, Staff B, LPN, stated, I did take care of this resident [Resident #1]. He did not refuse care when I took care of him. I was told by the night nurse [Staff A, LPN] that his blood sugar was high. I don't remember him telling me what the blood sugar was, he just said it was high. He did not refuse care that day. I did not try to get another accucheck, he didn't have orders to recheck his blood sugar. I didn't have orders to recheck the blood sugar. I wasn't told how high the blood sugar was. I did not ask how high it was. I was in the front [area of building] charting and apparently, he called 911. I was called and asked if he needed help, I told them [EMS] no, I would check on him. I went to the room, and he said, You are trying to kill me. I asked him why and he told me that 'his blood sugar, his insulin was wrong, and he needed to get short acting insulin, and we weren't ordering it for him. I told him that he had orders for long-acting insulin and that he refused to take it. He told me Yes, I do, but because I need short acting insulin I need to get out of here and you all are trying to kill me. This could have been avoided, I should have rechecked his blood sugar, I don't know why I didn't. During a telephone interview on 11/14/2024 at 9:18 AM, the Advanced Practice Registered Nurse (APRN) stated, I believe that situation happened over the weekend. I wasn't the on-call provider, but it was discussed Monday. The protocol they follow is normally blood sugar greater than 400 they notify their provider and then we give standard orders. We give them extra orders. Like I said, I wasn't on call that weekend but when it was reviewed come Monday, that night the nurse didn't notify the on-call provider, and they documented that they did. They did come back with orders on that and then they had hand off [change of] shift. I would have expected potentially that since it was a night shift going into day shift, because this was a morning blood sugar, if I do recall correctly. As well, that morning at breakfast time the patients now eating so that sugar should probably be rechecked 90 minutes after they eat to see how they process that meal and what their new sugar is going to be if they weren't getting that coverage and then reaching back out to the provider and letting them know, 'hey this person's blood sugar is still reading this number' and just keep reaching out to the provider until they get what they need. A resident has the risk of going into Diabetic Ketoacidosis if not properly monitored and treated for high blood sugar. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 11/14/2024 at 11:20 AM, the Medical Director stated, I remember a few things because I know the facility felt bad about the whole thing, you know while this was all happening. So, they had called me about it I think this happened over the weekend to my understanding. I know that there was also some frustration on the patient end I think they refused some glucose checks or refused insulin and then at that point I think they called 911. My expectations would be to 100% ensure that there's glucose monitoring, accuchecks, and of course a sliding scale. I mean every single diabetic in the building should be on a sliding scale. I think it was [the OCMD's name] that was notified. I think they went up on the long acting and they were just assuming that the patient was on a sliding scale. 100% if you're in the five hundreds [blood glucose level] and they're on long acting they need to be on a sliding scale, likely in the highest level of the sliding scale you know from there we could go up on the long acting and ensure there's proper glucose monitoring. I would probably give a onetime dose of a short acting and have them recheck sugars in an hour so I'm not sure what took place in this case or how long after that reading the patient called 911. I would want to be notified that they [resident] were refusing [medications]. I don't know if that call was ever made, after the fact, to let the doctor know that he's refusing it. If any doctor's increasing long-acting insulin, they're already assuming that the short acting is on the MAR. During an interview on 11/14/2024 at 7:10 AM, the DON stated, I was not here the day that this was found, that they spoke with his daughter, the Unit Manager spoke to her. They did know the concerns with not providing insulin or ADL [Activities of Daily Living] care. We were still investigating it; I can't tell you why we didn't investigate more. I knew his blood sugar was 552. I was given that information, but I thought it was that [Staff A's name] didn't transcribe orders. I guess we did not do a thorough investigation, I can't find any more than what was done initially and in the town hall meeting. I see that there were more than 12 hours that the resident was still here after that blood sugar of 552. There are no other accuchecks done after that. It is my expectation that staff provide a detailed report when going off their shift. The nurse [Staff A, LPN] should have told [Staff B's name] what the blood sugar was, and he [Staff A, LPN] should have documented his information in the notes. [Staff A's name] should have asked what high meant if that is what he told her. She should have followed up on that. I would expect that she called the doctor again and get further orders. She [Staff B] had the opportunity to call the doctor when he called 911 to get further orders. All the information should have been put in a progress note from both nurses. I would consider this neglect for both nurses. I don't know why the staff weren't suspended; I can't give you a reason. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/14/2024 at 4:10 PM, the Administrator stated, I can't say that I thought I needed to complete a federal report. I was told by [Staff D's name] that she [Resident #1's daughter] was upset and wanted to talk to us, but I wasn't able to connect with her. We attempted multiple times, but we couldn't reach her and left messages. When we got [in touch with] her is when I found out about her concerns with care related to the insulin and with being on the bedpan too long. We did do a QAPI on 10/7 related to the insulin. I just thought it was because he refused to take his insulin. I guess we did not investigate fully until after I spoke to his daughter. We thought the problem was that the nurse on admission got the right orders and there weren't accuchecks ordered. He refused this medication, and I spoke to [Staff B's name], LPN, and she told me that he [Resident #1] didn't talk to her at all about his insulin during the day before he called 911. Then they realized that he had orders that were not transcribed from the night nurse when he came on shift. I did not talk to him [Staff A, LPN] the DON did. I did not implement the abuse and neglect policies because he refused his medication. I didn't think to. I can't tell you why. We should have done more investigation. We should have done a QAPI when we realized that his blood sugar was so high, I wasn't aware of everything. We only did the initial QAPI, we didn't do any others, I think we should have done it, I can't tell you why we didn't. We did not suspend the nurses; it is our policy to suspend staff pending the results of an investigation. We initially thought it happened because the resident refused his insulin, not for neglect. We should follow our abuse and neglect policies and procedures. I didn't think to. I can't tell you why. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the policy and procedure titled Abuse, Neglect, Exploitation & Misappropriation last revision date of 11/16/2022, last approval date of 4/23/2024 read, Policy: It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies and procedures to protect these rights to establish a disciplinary policy which results in a fair and timely treatment of occurrences of resident abuse. Employees at the center are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment, and/or misappropriation of property. No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and or misappropriation of property against any resident. Violation of this standard will subject employees to disciplinary action including dismissal provided herein. Definitions: Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Procedure: 4. Identification: All reported events (bruises, skin tears, falls, inappropriate or abusive behaviors) will be investigated by the Director of Nursing/designee. Patterns or trends will be identified that might constitute abuse. This information will be forwarded to the Executive Director, who will serve as the facility's Abuse Coordinator, and an abuse investigation will be conducted in the absence of the Executive Director, the Director of Nursing will serve as the Abuse Coordinator. 5. Investigation: The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A Social Service representative may be offered in the role of resident advocate during a questioning of or interviewing of residents. Investigations will be accomplished in the following manner. Preliminary Investigation: Immediately upon an allegation of abuse or neglect, the suspect(s) should be segregated from residents pending the investigation of the resident allegation. The nurse or Director of Nursing/designee shall perform and document a thorough nursing evaluation and notify the attending physician. An incident report shall be filed by the individual in charge who received the report in conjunction with the person who reported the abuse. This report shall be filed as soon as possible in order to provide the most accurate information in a timely fashion and submitted to the Abuse Coordinator. Investigation: The Abuse Coordinator and/or Director of Nursing shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared. 6. Protection: Any suspect(s), who is employed or contract service provider, once he/she has(have) been identified, will be suspended pending the investigation. 7. Reporting/ Response: Any employee or contracted service provider who witnesses or has knowledge of an act of abuse or alleged allegation of abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property, to a resident is obligated to report such information immediately but no later than two hours after the allegation is made if the events that caused the allegation involve abuse or resulted in serious bodily injury for not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the administrator and to other officials in accordance with state law. In the absence of the executive director, the director of nursing is designated abuse coordinator. Once an allegation of abuse is reported, the executive director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with federal and state regulations, including notification of law enforcement if a reasonable suspicion of crime has occurred. Facility staff should be aware of and comply with their individual requirements and responsibilities for reporting as required by law. Staff should be aware of, and comply with, individual requirements and responsibilities for reporting as may be required by law. In all cases, the executive director or director of nursing will ensure notification to the residents' legal guardian, family member, responsible party, or significant other of the alleged, suspected or observed abuse, neglect or mistreatment, and the resident's attending physician. Coordination with QAPI: The center will review allegations of abuse, neglect, and misappropriation of resident property and exploitation during QAPI meetings. QAPI committee will review information including but not limited to: The thoroughness of the investigation, Protection of the resident(s), Risk factors identified, Root- cause analysis of the investigation, Systemic changes that may be required

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the policy and procedure titled Notification of Change of Condition last revision date of 12/16/2020 and last approval date of 4/23/2024 read, Policy: The Center 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 an accident, significant change in the patient residence physical, mental or psychosocial status, need to alter treatment significantly new treatment, discontinuation of current treatment due to but not limited to adverse consequences acute condition exacerbation of a chronic condition, a transfer or discharge of the patient resident from the center, patient/ resident consecutively refuses medication and or treatment (IE two or more times), patient/ resident is discharged without proper medical authority. Review of the policy and procedure titled Physician orders last revision date of 3/3/2021 and last approval date of 4/23/2024 read, Policy: The center will ensure that physician orders are appropriately and timely documented in the medical record. Procedure: Admission Orders: Information received from the referring facility or agency to be reviewed, verified with the physician and transcribed to the electronic medical record. The attending physician will review and confirm orders. Confirmation of admission orders requires that the physician sign and date the order during or as soon as practicable after it is provided, to maintain an accurate medical record. Routine orders: A nurse may accept a telephone order from a Physician, Physician Assistant or Nurse Practitioner (as permitted by state law) The order will be repeated back to the physician, PA or ARNP for his/her verbal confirmation. The order is transcribed to all appropriate areas of the electronic health record (eMAR/eTAR [electronic Treatment Administration Record]). For pharmacy orders, the nurse will notify the pharmacy per pharmacy policy by telephoning, faxing or completing the order electronically. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105460	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at North Florida	6700 NW 10th Place Gainesville, FL 32605

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy (IJ) was removed onsite on 11/18/2024 after the receipt of an acceptable IJ removal plan. The facility has completed the following steps to remove the immediate jeopardy. On 11/18/2024, the Executive Director completed a 30-day look back at all reportables to ensure proper investigation was conducted. On 11/18/2024, the Director of Nursing completed all hospital transfers, conducted a facility wide audit of change in conditions in the last 30 days pertaining to insulin with no additional concerns related to blood sugars. On 11/14/2024, education was provided to the Executive Director by the Regional [NAME] President on Abuse/Neglect policy and procedure to include investigations. The Regional Nurse Consultant provided abuse/ neglect education, as well as investigation to the nurse management staff on 11/13/2024. Education included: abuse/ neglect policy and procedure related to neglect for failure to reassess, notify the physician, not documenting physician's orders, not documenting communication to the physician, not documenting the transfer of the resident to the hospital, not following physician orders, and lack of shift-to-shift report. All incidents to be called to the Regional [NAME] President, Regional Director of Clinical Services, and Risk Manager with a timeline of events on any incident to determine if reportable. Investigations to be started immediately on any complaints or incidents. On 11/18/2024, the grievance log was reviewed for the last 30 days by Regional Director of Social Services with no concerns noted related to change of condition, insulin, abuse or neglect. On 11/18/2024, the Director of Nursing conducted a facility wide audit of all hospital transfers and change of condition in the last 30 days pertaining to insulin with no additional concerns related to blood sugars. On 11/13/2024, education was provided for all staff by the Director of Nursing/designee on the abuse neglect policy. Facility personnel received education beginning on 11/13/2024 and completed on 11/15/2024 related to the abuse/neglect policy to include preventing abuse, identification, protection, investigating and reporting inappropriate resident behaviors to the nurse. Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Key staff were educated on reporting process of a potential deficient practice or suspected abuse/neglect to the Quality Assurance performance Improvement (QA/PI) by notifying the Executive Director and/or the Director of Nursing. On 11/13/2024, an Ad Hoc that included the Executive Director, Medical Director, Director of Nursing the root cause analysis was the facility failed to initiate/implement the abuse/neglect policy including a complete investigation. The facility failed to identify areas not in compliance regarding the nurse failing to reassess the resident, failed to document the change in condition, lack of shift-to-shift report, insulin administration, Abuse/neglect identification and process, failed to follow policies and procedures when transferring resident to the hospital, and lack of communication between staff and providers. As of 11/17/2024, education has been completed on 40 out of 40 licensed nurses on medical neglect, accuchecks, insulin, Type 1 and 2 diabetes, and Change of Condition policy. On 11/17/2024, 68 of 68 Certified Nursing Assistants and 64 of 64 ancillary staff were also educated. Review of t [TRUNCATED]

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49444 Based on record review, interview, and review of policy and procedure, the facility failed to implement policies and procedures and fully investigate allegations of medical neglect for 1 of 3 residents reviewed for abuse and neglect, Resident #1. Findings include: Review of the Admission Record for Resident #1 documented an admitted [DATE] with diagnoses that include diabetes mellitus type 1, malignant neoplasm of oropharynx (cancer), unspecified dysphagia (unable to swallow), oropharyngeal phase, type 1 diabetes mellitus without complications, chronic pulmonary embolism (a blockage in a lung artery caused by a blood clot that has traveled from elsewhere in the body), chronic kidney disease, unspecified, other acute osteomyelitis (bone infection), unspecified site, acquired absence of left leg (below knee), essential primary hypertension (high blood pressure), gastrostomy status (a flexible tube that's surgically inserted into the stomach through the abdominal wall. It allows for the delivery of nutrition, fluids, and medication directly into the stomach), hyperlipidemia, unspecified (an abnormally high concentration of fats or lipids in the blood), peripheral vascular disease, unspecified (blood vessels narrow or become blocked, reducing blood flow to the limbs or other parts of the body). Review of Resident #1's physician order dated 10/4/2024 read, Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 10 units subcutaneously one time a day related to Type 1 Diabetes Mellitus Without Complications. Review of Resident #1's Medication Administration Record (MAR) showed Staff A, Licensed Practical Nurse (LPN) documented a bs (blood sugar) of 552 on 10/6/2024 at 6:00 AM. Staff A documented 2, CM (chart code/follow up codes 2=drug refused). Review of Resident #1's eMAR (electronic MAR) note dated 10/6/2024 at 6:32 AM showed Staff A, LPN, documented, Patient stated, I'm refusing all medications until I get the proper insulin. Review of Resident #1's progress note dated 10/6/2024 at 7:00 AM documented by Staff A, LPN, read, ARNP [Advanced Registered Nurse Practitioner] notified of resident's refusal of all morning medications. Per resident he is refusing all medications until he is receiving the proper insulin. Orders received to increase current insulin twice daily with blood sugars checked twice daily. No other orders given at this current time. Review of text message communication from Staff A, LPN's personal cellular phone to the On Call Medical Doctor (OCMD) on 10/6/2024 at 7:33 AM read, Good Morning, [Resident #1's name] is refusing all of his medications. He says he's not taking anything until he receives the proper insulin. Per his orders he's receiving 10 Units of Lantus @ [at] 6 am. He did allow me to check his blood sugar 552. Review of text message communication from the OCMD to Staff A, LPN's personal cellular phone on 10/6/2024 at 8:19 AM read, No sliding scale ordered? (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 8:22 AM read, No, I didn't see any sliding scale he said his Lantus is supposed to be given @ night. And he has another type of insulin he gets. I didn't see anything other than the Lantus. Review of text message communication from the OCMD to Staff A, LPN's personal cellular phone on 10/6/2024 at 10:55 AM read, Based on his sugars, if they have been above 250 everyday, go up to 15 BID [15 units two times a day] of long-acting insulin and make sure we cover with sliding scale for meals. Let's also make sure he's getting accuchecks. Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 7:55 PM read, I'll change his orders & notify him of the changes & hopefully he complies. Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 11:25 PM read, [Resident #1's last name] has continued to call 911 since I arrived this afternoon. They are loading him up & transporting him, [Resident #1's full name]. Review of Resident #1's Interact SBAR (Situation, Background, Assessment, Recommendations) Communication form documented by Staff A, LPN, dated 10/6/2024 at 11:25 PM read, Situation: the change in condition (CIC) reported on this CIC evaluation are: other change in condition. At the time of evaluation patient vital signs, weight and blood sugar were blood pressure 130/77, pulse 82, temperature 98.2, pulse oximetry 96% on room air, blood glucose of 552 obtained at 6:45 AM on 10/06/24. Outcomes of physical assessment: positive findings reported were mental status evaluation with no change observed. Functional status evaluation with no changes observed. Patient called 911 on his personal cell phone and stated, I want out of this place. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: No new orders given at this time. Review of Resident #1's medical record did not contain any documentation of the text message communication between the facility and the OCMD. Review of Resident #1's medical record showed no further blood glucose checks after the 552 documented at approximately 6:00 AM. Review of the hospital ED (Emergency Department) provider notes for Resident #1 dated 10/6/2024 at 11:51 PM read, Chief complaint: Patient presents with high blood sugar. Patient is an 81 y.o. [year old] M [male] with a PMH [Past Medical History] of oropharyngeal SCC [squamous cell cancer of throat], DVT [Deep Vein Thrombosis], PVD [Peripheral Vascular Disease], T1D [Type 1 Diabetes], HTN [Hypertension], and osteomyelitis who presents from an outside rehab after having unreadable glucose levels on his monitor. He states that at the outside rehab were not following his strict insulin regimen trying to give a different type of insulin. Per EMS [Emergency Medical Services] he was declining the insulin the outside rehab was trying to give him. He was recently admitted on ,d+[DATE] for pneumonia and was discharged to rehab NPO [nothing by mouth] with swallow study pending (gastrostomy tube in place). BASIC METABOLIC PANEL - Abnormal; Notable for the following components: Glucose 745, Anion Gap 34. Medical Evaluation Initiated: Attestation: The patient is critical due to DKA [Diabetic Ketoacidosis]. admitted to the ICU [Intensive Care Unit]. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospital history and physical for Resident #1 dated 10/7/2024 read, HPI [history of presenting illness]: [Resident #1's name] is an 81 y.o. male presented with hyperglycemia at rehab admitted for DKA. PMH relevant for T1DM (Type 1 Diabetes Mellitus), HTN, oropharyngeal squamous cell carcinoma, peripheral vascular disease, DVT (04/2022) and below the knee amputation secondary to osteomyelitis. Patient reports lack of compliance with his long-term insulin regimen for DM1 [Type 1 Diabetes Mellitus] at his rehab facility. He reports they weren't giving me the right insulin and explains some of the doses of his regimen were being missed. During an interview on 11/13/2024 at 9:25 AM, the Director of Nursing (DON) stated, I was not here for the incident, I found out after I returned that Tuesday. That was the 8th [10/8/2024]. With a blood sugar that high the nurse should have notified the doctor that he [Resident #1] was refusing his insulin and why he was refusing it. The nurse in charge of his care was not acting within the professional standards of practice for treating hyperglycemia in a type 1 diabetic. He [Staff A, LPN] should have notified the doctor immediately when he [Resident #1] refused his insulin. He [Staff A, LPN] did not transcribe the orders, and he should have stayed and transcribed the orders he got. The nurse got the high blood sugar and spoke to someone. I don't know who he spoke with, I don't know their name, you will have to ask [the Administrator's name] and got new orders. I don't know if or what he told the nurse that came on in the day shift. I don't know what the day shift nurse did after that. This shouldn't have happened; this should have been avoided. The nurse that admitted him should have read everything when it comes to the discharge summary, and they would have seen all the other orders instead of just the one piece of paper. The blood sugar should have been rechecked. It was not rechecked the rest of the day. I would consider this neglect. I don't know why the abuse and neglect policies were not followed. We should have completed a RCA [root cause analysis] and we should have implemented the abuse policy and procedure back on the 7th [10/7/2024]. During a telephone interview on 11/13/2024 at 11:35 AM, the OCMD stated, I did receive a call related to this resident [Resident #1]. The Nurse called me on the afterhours line, and I was told of the residents' glucose and I actually decided to double the insulin, the Lantus, and increase it to 15 Units twice a day and to add SSIC [Sliding Scale Insulin Coverage] with insulin coverage AC [before meals] and HS [at bedtime]. I would say that the professional standard of practice would be to have the blood glucose rechecked after 30 minutes to one hour after high readings to accurately assess if the patient was stabilizing versus the patient needing further emergency treatment. The staff did not adhere to a professional standard of practice when they did not notify us that he was refusing treatment. I would expect staff to inform us that a patient had refused insulin to determine the next steps we needed to do, either increase medications or we send to the hospital. I would call this unintentional neglect. They did not treat this according to professional standards of practice. I should have been notified that the patient was refusing his insulin. I was not called about this again after I gave the orders to them. During an interview on 11/13/2024 at 2:49 PM, Staff D, LPN, Unit Manager, stated, I found out when his daughter called me, she called on that Monday (October 7th). She was upset about him not getting his insulin and about what happened. This was after he left. She said she was a nurse and couldn't understand how we could make a mistake like this. She was very upset about it. She was upset that he was not given his proper insulin and that he was now in Diabetic ketoacidosis. I told [the Administrator's name]. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/2024 at 3:18 PM, the Administrator stated, I found out about the situation when I returned to work. I was finally able to speak with the daughter on 10/20/2024. I didn't file a report on 10/7/2024 because we saw on the chart that they only had orders for Lantus, we didn't think it was an issue until he started refusing the medication. The report should have been done, that is the best practice. [Staff A, LPN's name] got the order. It was not placed in [name of the electronic medical record software]. We investigated and did a QAPI [Quality Assurance and Process Improvement] Ad hoc [from Latin meaning for this] meeting on 10/7/2024. I talked to [Staff B's name], she said that the resident refused medications and [Staff A's name] spoke to the nurse practitioner and got orders. The nurse forgot to transcribe the orders into [name of the electronic medical record software]. There was no documentation in [name of the electronic medical record software]. During an interview on 11/13/2024 at 3:43 PM, Staff B, LPN, stated, I did take care of this resident [Resident #1]. He did not refuse care when I took care of him. I was told by the night nurse [Staff A, LPN] that his blood sugar was high. I don't remember him telling me what the blood sugar was, he just said it was high. He did not refuse care that day. I did not try to get another accucheck, he didn't have orders to recheck his blood sugar. I didn't have orders to recheck the blood sugar. I wasn't told how high the blood sugar was. I did not ask how high it was. I was in the front [area of building] charting and apparently, he called 911. I was called and asked if he needed help, I told them [EMS] no, I would check on him. I went to the room, and he said, You are trying to kill me. I asked him why and he told me that 'his blood sugar, his insulin was wrong, and he needed to get short acting insulin, and we weren't ordering it for him. I told him that he had orders for long-acting insulin and that he refused to take it. He told me Yes, I do, but because I need short acting insulin I need to get out of here and you all are trying to kill me. This could have been avoided, I should have rechecked his blood sugar, I don't know why I didn't. During an interview on 11/14/2024 at 7:10 AM, the DON stated, I was not here the day that this was found, that they spoke with his daughter, the Unit Manager spoke to her. They did know the concerns with not providing insulin or ADL [Activities of Daily Living] care. We were still investigating it; I can't tell you why we didn't investigate more. I knew his blood sugar was 552. I was given that information, but I thought it was that [Staff A's Name] didn't transcribe orders. I guess we did not do a thorough investigation, I can't find any more than what was done initially and in the town hall meeting. I see that there were more than 12 hours that the resident was still here after that blood sugar of 552. No, there are no other accuchecks done after that. It is my expectation that staff provide a detailed report when going off their shift. The nurse [Staff A, LPN] should have told [Staff B's name] what the blood sugar was, and he [Staff A, LPN] should have documented his information in the notes. [Staff A's name] should have asked what high meant if that is what he told her. She should have followed up on that. I would expect that she called the doctor again and get further orders. She [Staff B] had the opportunity to call the doctor when he called 911 to get further orders. All the information should have been put in a progress note from both nurses. I would consider this neglect for both nurses. I don't know why the staff weren't suspended; I can't give you a reason. We should have followed our policies on abuse. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/2024 at 4:10 PM, the Administrator stated, I can't say that I thought I needed to complete a federal report. I was told by [Staff D's name] that she [Resident #1's daughter] was upset and wanted to talk to us, but I wasn't able to connect with her. We attempted multiple times, but we couldn't reach her and left messages. When we got [in touch with] her is when I found out about her concerns with care related to the insulin and with being on the bedpan too long. We did do a QAPI on 10/7 related to the insulin. I just thought it was because he refused to take his insulin. I guess we did not investigate fully until after I spoke to his daughter. We thought the problem was that the nurse on admission got the right orders and there weren't accuchecks ordered. He refused this medication, and I spoke to [Staff B's name] and she told me that he [Resident #1] didn't talk to her at all about his insulin during the day before he called 911. Then they realized that he had orders that were not transcribed from the night nurse when he came on shift. I did not talk to him [Staff A, LPN], the DON did. I did not implement the abuse and neglect policies because he refused his medication. I didn't think to. I can't tell you why. We should have done more investigation. We should have done a QAPI when we realized that his blood sugar was so high, I wasn't aware of everything. We only did the initial QAPI, we didn't do any others, I think we should have done it, I can't tell you why we didn't. We did not suspend the nurses; it is our policy to suspend staff pending the results of an investigation. We initially thought it happened because the resident refused his insulin, not for neglect. We should follow our abuse and neglect policies and procedures. Review of Staff A's employee file showed no disciplinary action or suspension in place during the investigation. Review of the schedule for October and November 2024 documented that Staff A, LPN, worked on 10/7/2024, 10/10/2024, 10/11/2024, 10/12/2024, 10/14/2024, 10/15/2024, 10/19/2024, 10/20/2024, 10/21/2024, 10/24/2024, 10/25/2024, 10/26/2024, 10/28/2024, 10/29/2024, 10/31/2024, 11/01/2024, 11/02/2024, 11/03/2024, 11/04/2024, 11/07/2024, 11/08/2024, 11/09/2024, 11/11/2024, and on 11/12/2024. Review of the document titled Bull horn Time & Expense Payroll Company Staff A's timesheet clock in and clock out activity verified Staff A, LPN, clocked in for work on 10/7/2024, 10/10/2024, 10/11/2024, 10/12/2024, 10/14/2024, 10/15/2024, 10/19/2024, 10/20/2024, 10/21/2024, 10/24/2024, 10/25/2024, 10/26/2024, 10/28/2024, 10/29/2024, 10/31/2024, 11/01/2024, 11/02/2024, 11/03/2024, 11/04/2024, 11/07/2024, 11/08/2024, 11/09/2024, 11/11/2024, and on 11/12/2024. Review of Staff B's employee file showed no disciplinary action or suspension in place during the investigation. Review of the schedule for October and November 2024 documented that Staff B, LPN, worked on 10/07/2024, 10/09/2024, 10/11/2024, 10/12/2024, 10/16/2024, 10/18/2024, 10/22/2024, 10/23/2024, 10/24/2024, 10/25/2024, 10/26/2024, 11/03/2024, 11/04/2024, 11/06/2024, 11/07/2024, 11/08/2024, 11/09/2024, 11/13/2024, 11/1420/24, and 11/15/2024. Review of the document titled Bull horn Time & Expense Payroll Company Staff B's timesheet clock in and clock out activity documented that Staff B, LPN, clocked in for work on 10/07/2024, 10/09/2024, 10/11/2024, 10/12/2024, 10/16/2024, 10/18/2024, 10/22/2024, 10/23/2024, 10/24/2024, 10/25/2024, 10/26/2024, 11/03/2024, 11/04/2024, 11/06/2024, 11/07/2024, 11/08/2024, 11/09/2024, 11/13/2024, 11/1420/24, and 11/15/2024. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy and procedure titled Abuse, Neglect, Exploitation & Misappropriation last revision date of 11/16/2022, last approval date of 4/23/2024 read, Policy: It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies and procedures to protect these rights to establish a disciplinary policy which results in a fair and timely treatment of occurrences of resident abuse. Employees at the center are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment, and/or misappropriation of property. No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and or misappropriation of property against any resident. Violation of this standard will subject employees to disciplinary action including dismissal provided herein. Definitions: Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Procedure: 4. Identification: All reported events (bruises, skin tears, falls, inappropriate or abusive behaviors) will be investigated by the Director of Nursing/designee. Patterns or trends will be identified that might constitute abuse. This information will be forwarded to the Executive Director, who will serve as the facility's Abuse Coordinator, and an abuse investigation will be conducted in the absence of the Executive Director, the Director of Nursing will serve as the Abuse Coordinator. 5. Investigation: The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A Social Service representative may be offered in the role of resident advocate during a questioning of or interviewing of residents. Investigations will be accomplished in the following manner. Preliminary Investigation: Immediately upon an allegation of abuse or neglect, the suspect(s) should be segregated from residents pending the investigation of the resident allegation. The nurse or Director of Nursing/designee shall perform and document a thorough nursing evaluation and notify the attending physician. An incident report shall be filed by the individual in charge who received the report in conjunction with the person who reported the abuse. This report shall be filed as soon as possible in order to provide the most accurate information in a timely fashion and submitted to the Abuse Coordinator. Investigation: The Abuse Coordinator and/or Director of Nursing shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared. 6. Protection: Any suspect(s), who is employed or contract service provider, once he/she has(have) been identified, will be suspended pending the investigation. 7. Reporting/ Response: Any employee or contracted service provider who witnesses or has knowledge of an act of abuse or alleged allegation of abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property, to a resident is obligated to report such information immediately but no later than two hours after the allegation is made if the events that caused the allegation involve abuse or resulted in serious bodily injury for not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the administrator and to other officials in accordance with state law. In the absence of the executive director, the director of nursing is designated abuse coordinator. Once an allegation of abuse is reported, the executive director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with federal and state regulations, including notification of law enforcement if a reasonable suspicion of crime has occurred. Facility staff should be aware of and comply with their individual requirements and responsibilities for reporting as required by law. Staff should be aware of, and comply with, individual requirements and responsibilities for reporting as may be required by law. In all cases, the executive director or director of nursing will ensure notification to the residents' legal guardian, family member, responsible party, or significant other of the alleged, suspected or observed abuse, neglect or mistreatment, and the resident's attending physician. Coordination with QAPI: The center will review allegations of abuse, neglect, and misappropriation of resident property and exploitation during QAPI meetings. QAPI committee will review information including but not limited to: The thoroughness of the investigation, Protection of the resident(s), Risk factors identified, Root- cause analysis of the investigation, Systemic changes that may be required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105460	A. Building B. Wing	11/19/2024

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 49444 Based on interview, record review, and review of policy and procedures, the facility failed to ensure residents who required insulin administration received treatment in accordance with professional standards of practice by failing to notify and immediately consult with the resident's physician when a resident suffered elevated blood glucose levels. On 10/6/2024 at 6:00 AM, Resident #1 had a blood sugar value of 552 and the on-call provider was notified of the value and the resident stated he was refusing medications until he received the proper insulin. Staff A, Licensed Practical Nurse, (LPN), did not communicate to Staff B, LPN or transcribe the new orders into the medical record for the increase in insulin and the addition of sliding scale insulin coverage. Staff B, LPN, assumed care of Resident #1 at 7:00 AM on 10/6/2024 and did not follow up with the provider. Staff B, LPN, did not reassess Resident #1's blood glucose or address the need for any orders. Resident #1 called 911 at approximately 6:30 PM, Emergency Medical Services (EMS) contacted the facility, spoke with Staff B, LPN, who instructed EMS the resident did not need help. Again at 11:15 PM, Resident #1 called 911 and was subsequently transferred to the hospital and was admitted to the Intensive Care Unit with a diagnosis of Diabetic Ketoacidosis. Diabetic ketoacidosis (DKA) develops when the body can't make enough insulin, a hormone that helps sugar enter cells for energy. Instead, fat is broken down for energy. This can cause acids called ketones to build up in the blood and collect in the urine. The risk is highest in people who have type 1 diabetes and those who often miss insulin doses. DKA symptoms often start quickly, sometimes within a day. A person may get very thirsty, urinate often, vomit or have stomach pain. Symptoms also can include tiredness or weakness, confusion, shortness of breath, or fruity breath. Treatment often involves going to a hospital to receive fluids, insulin and electrolytes through a vein. Without treatment, diabetic ketoacidosis can lead to loss of consciousness and death. (Mayo Clinic/Mayoclinic.org) The facility's failure to implement the policy and procedure for change of condition and physician notification and failure to ensure residents who required insulin administration received treatment in accordance with professional standards of practice led to a determination of Immediate Jeopardy at a scope and severity of isolated (J). The Nursing Home Administrator was notified of the Immediate Jeopardy on November 18, 2024, at 2:50 PM. The Immediate Jeopardy began on October 6, 2024, and was removed on site on November 18, 2024. Findings include: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Admission Record for Resident #1 documented an admitted [DATE] with diagnoses that include diabetes mellitus type 1, malignant neoplasm of oropharynx (cancer), unspecified dysphagia (unable to swallow), oropharyngeal phase, type 1 diabetes mellitus without complications, chronic pulmonary embolism (a blockage in a lung artery caused by a blood clot that has traveled from elsewhere in the body), chronic kidney disease, unspecified, other acute osteomyelitis (bone infection), unspecified site, acquired absence of left leg (below knee), essential primary hypertension (high blood pressure), gastrostomy status (a flexible tube that's surgically inserted into the stomach through the abdominal wall. It allows for the delivery of nutrition, fluids, and medication directly into the stomach), hyperlipidemia, unspecified (an abnormally high concentration of fats or lipids in the blood), peripheral vascular disease, unspecified (blood vessels narrow or become blocked, reducing blood flow to the limbs or other parts of the body). Review of Resident #1's physician order dated 10/4/2024 read, Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 10 units subcutaneously one time a day related to Type 1 Diabetes Mellitus Without Complications. Review of Resident #1's Medication Administration Record (MAR) showed Staff A, LPN, documented a BS (blood sugar) of 552 on 10/6/2024 at 6:00 AM. Staff A, LPN, documented 2, CM (chart code/follow up codes 2 = drug refused). Review of Resident #1's eMAR (electronic Medication Administration Record) note dated 10/6/2024 at 6:32 AM documented by Staff A, LPN, read, Patient stated, I'm refusing all medications until I get the proper insulin. Review of Resident #1's progress note dated 10/6/2024 at 7:00 AM documented by Staff A, LPN, read, ARNP [Advanced Registered Nurse Practitioner] notified of resident's refusal of all morning medications. Per resident he is refusing all medications until he is receiving the proper insulin. Orders received to increase current insulin twice daily with blood sugars checked twice daily. No other orders given at this current time. Review of text message communication from Staff A, LPN's personal cellular phone to the On Call Medical Doctor (OCMD) on 10/6/2024 at 7:33 AM read, Good Morning, [Resident #1's name] is refusing all of his medications. He says he's not taking anything until he receives the proper insulin. Per his orders he's receiving 10 Units of Lantus @ [at] 6 am. He did allow me to check his blood sugar 552. Review of text message communication from the OCMD to Staff A, LPN's personal cellular phone on 10/6/2024 at 8:19 AM read, No sliding scale ordered? Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 8:22 AM read, No, I didn't see any sliding scale he said his Lantus is supposed to be given @ night. And he has another type of insulin he gets. I didn't see anything other than the Lantus. Review of text message communication from the OCMD to Staff A, LPN's personal cellular phone on 10/6/2024 at 10:55 AM read, Based on his sugars, if they have been above 250 everyday, go up to 15 BID [15 units two times a day] of long-acting insulin and make sure we cover with sliding scale for meals. Let's also make sure he's getting accuchecks. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 7:55 PM read, I'll change his orders & notify him of the changes & hopefully he complies. Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 11:25 PM read, [Resident #1's last name] has continued to call 911 since I arrived this afternoon. They are loading him up & transporting him, [Resident #1's full name]. Review of Resident #1 medical record did not contain any documentation of the test message communication between the facility and the OCMD. Review of Resident #1's Interact SBAR (Situation, Background, Assessment, Recommendations) Communication form documented by Staff A, LPN, dated 10/6/2024 at 11:25 PM read, Situation: the change in condition (CIC) reported on this CIC evaluation are: other change in condition. At the time of evaluation patient vital signs, weight and blood sugar were blood pressure 130/77, pulse 82, temperature 98.2, pulse oximetry 96% on room air, blood glucose of 552 obtained at 6:45 AM on 10/06/24. Outcomes of physical assessment: positive findings reported were mental status evaluation with no change observed. Functional status evaluation with no changes observed. Patient called 911 on his personal cell phone and stated, I want out of this place. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: No new orders given at this time. Review of Resident #1's medical record did not contain any documentation of further blood glucose checks after the glucose level of 552 was documented at approximately 6:00 AM. Review of the hospital ED (Emergency Department) provider notes for Resident #1 dated 10/6/2024 at 11:51 PM read, Chief complaint: Patient presents with high blood sugar. Patient is an 81 y.o. [year old] M [male] with a PMH [Past Medical History] of oropharyngeal SCC [squamous cell cancer of throat], DVT [Deep Vein Thrombosis], PVD [Peripheral Vascular Disease], T1D [Type 1 Diabetes], HTN [Hypertension], and osteomyelitis who presents from an outside rehab after having unreadable glucose levels on his monitor. He states that at the outside rehab were not following his strict insulin regimen trying to give a different type of insulin. Per EMS [Emergency Medical Services] he was declining the insulin the outside rehab was trying to give him. He was recently admitted on ,d+[DATE] for pneumonia and was discharged to rehab NPO [nothing by mouth] with swallow study pending (gastrostomy tube in place). BASIC METABOLIC PANEL - Abnormal; Notable for the following components: Glucose 745, Anion Gap 34. Medical Evaluation Initiated: Attestation: The patient is critical due to DKA [Diabetic Ketoacidosis]. admitted to the ICU [Intensive Care Unit]. Review of the hospital history and physical for Resident #1 dated 10/7/2024 read, HPI [history of presenting illness]: [Resident #1's name] is an 81 y.o. male presented with hyperglycemia at rehab admitted for DKA. PMH relevant for T1DM (Type 1 Diabetes Mellitus), HTN, oropharyngeal squamous cell carcinoma, peripheral vascular disease, DVT (04/2022) and below the knee amputation secondary to osteomyelitis. Patient reports lack of compliance with his long-term insulin regimen for DM1 [Type 1 Diabetes Mellitus] at his rehab facility. He reports they weren't giving me the right insulin and explains some of the doses of his regimen were being missed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/13/2024 at 9:25 AM, the Director of Nursing (DON) stated, I was not here for the incident, I found out after I returned that Tuesday. That was the 8th [10/8/2024]. With a blood sugar that high the nurse should have notified the doctor that he [Resident #1] was refusing his insulin and why he was refusing it. The nurse in charge of his care was not acting within the professional standards of practice for treating hyperglycemia in a type 1 diabetic. He [Staff A, LPN] should have notified the doctor immediately when he [Resident #1] refused his insulin. He [Staff A, LPN] did not transcribe the orders, and he should have stayed and transcribed the orders he got. The nurse got the high blood sugar and spoke to someone. I don't know who he spoke with, I don't know their name, you will have to ask [the Administrator's name] and got new orders. I don't know if or what he told the nurse that came on in the day shift. I don't know what the day shift nurse did after that. This shouldn't have happened; this should have been avoided. The nurse that admitted him should have read everything when it comes to the discharge summary, and they would have seen all the other orders instead of just the one piece of paper. The blood sugar should have been rechecked. It was not rechecked the rest of the day. I would consider this neglect. I don't know why the abuse and neglect policies were not followed. We should have completed a RCA [root cause analysis] and we should have implemented the abuse policy and procedure back on the 7th [10/7/2024]. During a telephone interview on 11/13/2024 at 11:35 AM, the OCMD stated, I did receive a call related to this resident [Resident #1]. The Nurse called me on the afterhours line, and I was told of the residents' glucose and I actually decided to double the insulin, the Lantus, and increase it to 15 Units twice a day and to add SSIC [Sliding Scale Insulin Coverage] with insulin coverage AC [before meals] and HS [at bedtime]. I would say that the professional standard of practice would be to have the blood glucose rechecked after 30 minutes to one hour after high readings to accurately assess if the patient was stabilizing versus the patient needing further emergency treatment. The staff did not adhere to a professional standard of practice when they did not notify us that he was refusing treatment. I would expect staff to inform us that a patient had refused insulin to determine the next steps we needed to do, either increase medications or we send to the hospital. I would call this unintentional neglect. They did not treat this according to professional standards of practice. I should have been notified that the patient was refusing his insulin. I was not called about this again after I gave the orders to them. During an interview on 11/13/2024 at 2:28 PM, Staff E, LPN, Wound Care Nurse, stated, The nurse that admitted this resident did not identify it, that more than Lantus should have been ordered for him. The night nurse did get the high blood sugar and called the nurse practitioner and got orders. I don't know if he told the day nurse, I don't know. The hospital MAR conflicts with the discharge summary. He [Staff A, LPN] didn't transcribe the orders he got. He should have. During an interview on 11/13/2024 at 2:49 PM, Staff D, LPN, Unit Manager, stated, I found out [about incident] when his daughter called me, she called on that Monday [10/7/2024]. She was upset about him not getting his insulin and about what happened, this was after he went to the hospital. She said she was a nurse and couldn't understand how we could make a mistake like this. She was very upset about it. She was upset that he was not given his proper insulin and that he was now in Diabetic ketoacidosis. I told [the Administrator's name]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/13/2024 at 3:18 PM, the Administrator stated, I found out about the situation when I returned to work. I was finally able to speak with the daughter on 10/20/2024. I didn't file a report on 10/7/2024 because we saw on the chart that they only had orders for Lantus, we didn't think it was an issue until he started refusing the medication. The report should have been done, that is the best practice. [Staff A, LPN's name] got the order. It was not placed in [name of the electronic medical record software]. We investigated and did a QAPI [Quality Assurance and Process Improvement] Ad hoc [from Latin meaning for this] meeting on 10/7/2024. I talked to [Staff B's name], she said that the resident refused medications and [Staff A's name] spoke to the nurse practitioner and got orders. The nurse forgot to transcribe the orders into [name of the electronic medical record software]. There was no documentation in [name of the electronic medical record software]. During an interview on 11/13/2024 at 3:43 PM, Staff B, LPN, stated, I did take care of this resident [Resident #1]. He did not refuse care when I took care of him. I was told by the night nurse [Staff A, LPN] that his blood sugar was high. I don't remember him telling me what the blood sugar was, he just said it was high. He did not refuse care that day. I did not try to get another accucheck, he didn't have orders to recheck his blood sugar. I didn't have orders to recheck the blood sugar. I wasn't told how high the blood sugar was. I did not ask how high it was. I was in the front [area of building] charting and apparently, he called 911. I was called and asked if he needed help, I told them [EMS] no, I would check on him. I went to the room, and he said, You are trying to kill me. I asked him why and he told me that 'his blood sugar, his insulin was wrong, and he needed to get short acting insulin, and we weren't ordering it for him. I told him that he had orders for long-acting insulin and that he refused to take it. He told me Yes, I do, but because I need short acting insulin I need to get out of here and you all are trying to kill me. This could have been avoided, I should have rechecked his blood sugar, I don't know why I didn't. During a telephone interview on 11/14/2024 at 9:18 AM, the Advanced Practice Registered Nurse (APRN) stated, I believe that situation happened over the weekend. I wasn't the on-call provider, but it was discussed Monday. The protocol they follow is normally blood sugar greater than 400 they notify their provider and then we give standard orders. We give them extra orders. Like I said, I wasn't on call that weekend but when it was reviewed come Monday, that night the nurse didn't notify the on-call provider, and they documented that they did. They did come back with orders on that and then they had hand off [change of] shift. I would have expected potentially that since it was a night shift going into day shift, because this was a morning blood sugar, if I do recall correctly. As well, that morning at breakfast time the patients now eating so that sugar should probably be rechecked 90 minutes after they eat to see how they process that meal and what their new sugar is going to be if they weren't getting that coverage and then reaching back out to the provider and letting them know, 'hey this person's blood sugar is still reading this number' and just keep reaching out to the provider until they get what they need. A resident has the risk of going into Diabetic Ketoacidosis if not properly monitored and treated for high blood sugar. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 11/14/2024 at 11:20 AM, the Medical Director stated, I remember a few things because I know the facility felt bad about the whole thing, you know while this was all happening. So, they had called me about it I think this happened over the weekend to my understanding. I know that there was also some frustration on the patient end I think they refused some glucose checks or refused insulin and then at that point I think they called 911. My expectations would be to 100% ensure that there's glucose monitoring, accuchecks, and of course a sliding scale. I mean every single diabetic in the building should be on a sliding scale. I think it was [the OCMD's name] that was notified. I think they went up on the long acting and they were just assuming that the patient was on a sliding scale. 100% if you're in the five hundreds [blood glucose level] and they're on long acting they need to be on a sliding scale, likely in the highest level of the sliding scale you know from there we could go up on the long acting and ensure there's proper glucose monitoring. I would probably give a onetime dose of a short acting and have them recheck sugars in an hour so I'm not sure what took place in this case or how long after that reading the patient called 911. I would want to be notified that they [resident] were refusing [medications]. I don't know if that call was ever made, after the fact, to let the doctor know that he's refusing it. If any doctor's increasing long-acting insulin, they're already assuming that the short acting is on the MAR. During an interview on 11/14/2024 at 7:10 AM, the DON stated, I was not here the day that this was found, that they spoke with his daughter, the Unit Manager spoke to her. They did know the concerns with not providing insulin or ADL [Activities of Daily Living] care. We were still investigating it; I can't tell you why we didn't investigate more. I knew his blood sugar was 552. I was given that information, but I thought it was that [Staff A's name] didn't transcribe orders. I guess we did not do a thorough investigation, I can't find any more than what was done initially and in the town hall meeting. I see that there were more than 12 hours that the resident was still here after that blood sugar of 552. There are no other accuchecks done after that. It is my expectation that staff provide a detailed report when going off their shift. The nurse [Staff A, LPN] should have told [Staff B's name] what the blood sugar was, and he [Staff A, LPN] should have documented his information in the notes. [Staff A's name] should have asked what high meant if that is what he told her. She should have followed up on that. I would expect that she called the doctor again and get further orders. She [Staff B] had the opportunity to call the doctor when he called 911 to get further orders. All the information should have been put in a progress note from both nurses. I would consider this neglect for both nurses. I don't know why the staff weren't suspended; I can't give you a reason. Review of the policy and procedure titled Notification of Change of Condition last revision date of 12/16/2020 and last approval date of 4/23/2024 read, Policy: The Center 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 an accident, significant change in the patient residence physical, mental or psychosocial status, need to alter treatment significantly new treatment, discontinuation of current treatment due to but not limited to adverse consequences acute condition exacerbation of a chronic condition, a transfer or discharge of the patient resident from the center, patient/ resident consecutively refuses medication and or treatment (IE two or more times), patient/ resident is discharged without proper medical authority. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the policy and procedure titled Physician orders last revision date of 3/3/2021 and last approval date of 4/23/2024 read, Policy: The center will ensure that physician orders are appropriately and timely documented in the medical record. Procedure: Admission Orders: Information received from the referring facility or agency to be reviewed, verified with the physician and transcribed to the electronic medical record. The attending physician will review and confirm orders. Confirmation of admission orders requires that the physician sign and date the order during or as soon as practicable after it is provided, to maintain an accurate medical record. Routine orders: A nurse may accept a telephone order from a Physician, Physician Assistant or Nurse Practitioner (as permitted by state law) The order will be repeated back to the physician, PA or ARNP for his/her verbal confirmation. The order is transcribed to all appropriate areas of the electronic health record (eMAR/eTAR [electronic Treatment Administration Record]). For pharmacy orders, the nurse will notify the pharmacy per pharmacy policy by telephoning, faxing or completing the order electronically. The Immediate Jeopardy (IJ) was removed onsite on 11/18/2024 after the receipt of an acceptable IJ removal plan. The facility has completed the following steps to remove the immediate jeopardy. On 11/13/2024, an Ad Hoc was completed in the presence of the Executive Director, Medical Director and the Director of Nursing, to identify the root cause analysis was that the facility failed to ensure residents were free from complications of a change in condition due to not reassessing residents, not transcribing and administering ordered medication, not properly notifying the physician and not properly identifying the change in condition. On 11/13/2024, 40 of 40 licensed staff were educated on the change of condition process notifying the provider of abnormal blood glucose levels, notification of change, refusal of medications, assessment and reassessments for abnormal glucose levels and other change in condition, and transcribing and administration of physician orders. On 11/18/2024, The Director of Nursing completed a full house audit of 18 hospital transfers and 16 changes in conditions over the last 30 days with no deficient practice noted related to blood sugars, insulin, and transcribing/administering. Review of the facility records documented that there were 18 transfers to the hospital with the last 30 days and none were a result of blood sugars or hyperglycemia. Review of the facility records documented that there were 16 changes in condition within the last 30 days and none were a result of blood sugars or hyperglycemia. Review of the facility records documented an in-service dated 11/13/2024 on the topic of abuse/neglect presented by the Regional Director of Clinical Services was provided to the nursing management staff, the Director of Clinical Services, Assistant Director of Clinical services, and two Unit Managers. Review of the education in-service attendance record dated 11/14/2024 documented that the Executive Director received education on abuse and neglect training (reporting requirements) from the Regional [NAME] President of Operations. Review of the facility records beginning 11/13/2024 and completed on 11/17/2024 documented that 40 out of 40 licensed staff received training on Abuse and Neglect, 68 out of 68 Certified Nursing Assistants and 64 out of 64 ancillary staff received training on abuse and neglect, assessment and reassessment of residents, change-in-condition process, hospital transfer process, communication during shift-to-shift report, insulin administration, abuse/neglect identification and process and communication between staff and providers During staff interviews conducted 11/13/2024 through 11/19/2024, 19 Licensed Practical Nurses, 2 Registered Nurses, the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Wound Care Nurse, Staffing Coordinator, Business Office manager and Social Service Manager verified receiving the training and verbalized understanding of the abuse and neglect, changes in condition policies and procedures, resident reassessment after changes in condition.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49444 Based on interview, record review, and review of policies and procedures, the facility administration failed to administer the facility in a manner that enables it to use its resources effectively and efficiently to attain and maintain the highest practicable physical wellbeing of each resident by failing to implement policy and procedures for medical neglect and resident change of condition. On 10/6/2024 at 6:00 AM, Resident #1 had a blood sugar value of 552 and the on-call provider was notified of the value and the resident stated he was refusing medications until he received the proper insulin. Staff A, Licensed Practical Nurse, (LPN), did not communicate to Staff B, LPN or transcribe the new orders into the medical record for the increase in insulin and the addition of sliding scale insulin coverage. Staff B, LPN, assumed care of Resident #1 at 7:00 AM on 10/6/2024 and did not follow up with the provider. Staff B, LPN, did not reassess Resident #1's blood glucose or address the need for any orders. Resident #1 called 911 at approximately 6:30 PM, Emergency Medical Services (EMS) contacted the facility, spoke with Staff B, LPN, who instructed EMS the resident did not need help. Again at 11:15 PM, Resident #1 called 911 and was subsequently transferred to the hospital and was admitted to the Intensive Care Unit with a diagnosis of Diabetic Ketoacidosis. The facility's failure to implement the policy and procedure for medical neglect and failure to ensure residents who required insulin administration received treatment in accordance with professional standards of practice led to a determination of Immediate Jeopardy at a scope and severity of isolated (J). The Nursing Home Administrator was notified of the Immediate Jeopardy on November 18, 2024, at 2:50 PM. The Immediate Jeopardy began on October 6, 2024, and was removed on site on November 18, 2024. Findings include: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105460	A. Building B. Wing	11/19/2024

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the job description titled Executive Director I read, Purpose of Your Job Position: The Executive Director I is responsible for management of the facility in a manner which exemplifies the company's standard of operational excellence. The primary purpose of the executive director is to direct the day-to-day functions of the facility in accordance with current federal, state, their local standards, guidelines, and regulations that govern nursing facilities to ensure the highest degree of quality care can be provided to our residents at all times. You are entrusted to provide innovative, responsible healthcare with the creation and implementation of new ideas and concepts that continually improve systems and processes to achieve superior results. Job Functions: As Executive Director 1, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. Responsible for day-to-day clinical and administrative activities of the facility, including profit and loss responsibility and ensures compliance with all state and federal regulations. Duties and Responsibilities: 6. Interpret and ensure implementation of governing board policies and procedures. 9. Maintain and guide the implementation of facility policies and procedures in compliance with corporate, state, federal, and other regulatory guidelines. 11. Support and guide the facility's quality improvement process. 13. Ensure a safe, clean and comfortable environment for residents, visitors and staff. Maintain a file for and monitor incident reports.14. Attend and or conduct facility meetings, as required to carry out responsibilities. 23. Adhere to facility policies and procedures and participates in facility quality improvement and safety programs. 24. Attend to overall operation of the facility. Review of the job description titled Director of Nursing I read, Purpose of Your Job Position: As the company Director of Nursing, you are entrusted with the responsibility of caring for our residents, families, coworkers, visitors, and all others. The primary purpose of your job position is to plan, organize, develop and direct the overall operation of our nursing service department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be directed by the Executive Director to ensure that the highest degree of quality care is maintained at all times. You are entrusted to provide innovative, responsible health care with the creation and implementation of new ideas and concepts that continually improve systems and processes to achieve superior results. Job Functions: As Director of Nursing I, you are delegated the administrative authority responsibility and accountability necessary for carrying out your assigned duties. Responsible for planning, organizing and directing the functions for the nursing department. You will assume the primary role in ensuring the delivery of high quality, efficient nursing care. Supervises Nurse Practitioner, Assistant Director of Nursing, Clinical Nurses, and Nurse techs. In the absence of the Executive Director, you are in charge of carrying out the resident care policies established by the facility. Duties and responsibilities: 4. Set and monitor achievement of goals and objectives for the nursing department consistent with established philosophy and standards of practice. 6. Establish, implement, and continually update competency/skills checklists for nursing staff. 8. Maintain and guide the implementation of current policies and procedures, which reflect adherence to corporate and external regulatory guidelines. 9. Assure compliance with resident rights policies and work to resolve resident grievances. 10. Establish and monitor compliance with an effective medical record documentation system. 13. Actively participate in quality improvement process for the facility. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the job description titled Assistant Director of Clinical Services (ADON) read, Purpose of Your Job Position. As an Assistant Director of Clinical Services, you are entrusted with the responsibility of caring for our residents, families, coworkers, visitors and all others. The primary purpose of your position is to monitor clinical compliance with state and federal regulations. You are entrusted to provide innovative, responsible health care with the creation and implementation of new ideas and concepts that continually improve systems and processes to achieve superior results. Job functions as assistant director of clinical services, you are delegated the administrative authority, responsibility and accountability necessary for carrying out your assigned duties. Responsible for the functions of the corporate clinical and clinical reimbursement services department. Duties and responsibilities: 1. access to liaison between the director of nursing and the nursing staff. 2. participates in the development and achievement of nursing department goals and objectives. 4. assist in the implementation of and monitor compliance with policies, procedures, and standards of practice consistent with corporate and external regulatory guidelines. 6. Assist in the development, implementation, and monitoring of an accurate and effective documentation system. 10. Actively participate in the quality improvement process for the facility. 12. Attend and participate in department facility meetings as required. 15. Adheres to facility policies and procedures and participates in facility quality improvement and safety programs. 21. Perform other duties, as assigned. Review of the Medical Director Administrative Service Agreement read, 2. Responsibilities: a. OF GROUP: Group agrees that medical director shall generally be responsible for the administrative oversight of medical services at the care center, including, without limitation, the duties described in Exhibit A (the Administrative Services). Review of Exhibit A, Medical Director Services, read, The responsibilities of the Medical Director shall be, without limitation, to perform the following duties to be solely administrative in nature and not including any clinical or other direct medical services: (A) Make good faith efforts to ensure adequate medical care for patients. (B) Provide clinical leadership through active participation in the care centers quality assurance committee, and participate in all other activities which may be designated by the Executive Director of the Care Center from time to time to facilitate the cost-effective delivery of quality services at the care center. (D) Participate in such case management and risk management activities and programs as the executive director of the care center may request from time to time. (E) Maintain a current knowledge of all federal, state, and local laws, and rules and regulations regarding the medical directors practice and medical staff requirements. (I) The Medical Director will be responsible for monitoring and managing quality improvement goals. a. The Medical Director shall participate in monthly medical director's call. c. The Medical Director must address any concerning trends with regard to quality improvement. (L) Assist in the implementation and further development of care center programs, protocols, and quality assurance initiatives. (O). Participate in the development of written policies, rules and regulations to govern the nursing care and related medical and other health services provided. The medical director is responsible for seeing that these policies reflect an awareness of, and provisions for, meeting the total needs of Care Centers patients. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Admission Record for Resident #1 documented an admitted [DATE] with diagnoses that include diabetes mellitus type 1, malignant neoplasm of oropharynx (cancer), unspecified dysphagia (unable to swallow), oropharyngeal phase, type 1 diabetes mellitus without complications, chronic pulmonary embolism (a blockage in a lung artery caused by a blood clot that has traveled from elsewhere in the body), chronic kidney disease, unspecified, other acute osteomyelitis (bone infection), unspecified site, acquired absence of left leg (below knee), essential primary hypertension (high blood pressure), gastrostomy status (a flexible tube that's surgically inserted into the stomach through the abdominal wall. It allows for the delivery of nutrition, fluids, and medication directly into the stomach), hyperlipidemia, unspecified (an abnormally high concentration of fats or lipids in the blood), peripheral vascular disease, unspecified (blood vessels narrow or become blocked, reducing blood flow to the limbs or other parts of the body). Review of the document titled Department of Internal Medicine Discharge Summary Heme/Onc [Hematology/Oncology] Team dated 10/3/2024 read: (page 1) Instructions for PCP [Primary Care Physician]: will need to keep an eye on his insulin regimen as these have been up and down since starting bolus tube feeds; currently on 12 units long acting and seven units short acting before bolus feeds. Consider endocrinology referral. (page 8) Discharge medication, mediation list documents Lantus Solostar 100/unit/ML [milliliter] Insulin glargine. Inject 10 units into the skin every 24 hours. Review of Resident #1's physician order dated 10/4/2024 read, Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 10 units subcutaneously one time a day related to Type 1 Diabetes Mellitus Without Complications. Review of Resident #1's Medication Administration Record (MAR) showed Staff A, LPN, documented a BS (blood sugar) of 552 on 10/6/2024 at 6:00 AM. Staff A, LPN, documented 2, CM (chart code/follow up codes 2 = drug refused). Review of Resident #1's eMAR (electronic Medication Administration Record) note dated 10/6/2024 at 6:32 AM documented by Staff A, LPN, read, Patient stated, I'm refusing all medications until I get the proper insulin. Review of Resident #1's progress note dated 10/6/2024 at 7:00 AM documented by Staff A, LPN, read, ARNP [Advanced Registered Nurse Practitioner] notified of resident's refusal of all morning medications. Per resident he is refusing all medications until he is receiving the proper insulin. Orders received to increase current insulin twice daily with blood sugars checked twice daily. No other orders given at this current time. Review of text message communication from Staff A, LPN's personal cellular phone to the On Call Medical Doctor (OCMD) on 10/6/2024 at 7:33 AM read, Good Morning, [Resident #1's name] is refusing all of his medications. He says he's not taking anything until he receives the proper insulin. Per his orders he's receiving 10 Units of Lantus @ [at] 6 am. He did allow me to check his blood sugar 552. Review of text message communication from the OCMD to Staff A, LPN's personal cellular phone on 10/6/2024 at 8:19 AM read, No sliding scale ordered? Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 8:22 AM read, No, I didn't see any sliding scale he said his Lantus is supposed to be given @ night. And he has another type of insulin he gets. I didn't see anything other than the Lantus. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of text message communication from the OCMD to Staff A, LPN's personal cellular phone on 10/6/2024 at 10:55 AM read, Based on his sugars, if they have been above 250 everyday, go up to 15 BID [15 units two times a day] of long-acting insulin and make sure we cover with sliding scale for meals. Let's also make sure he's getting accuchecks. Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 7:55 PM read, I'll change his orders & notify him of the changes & hopefully he complies. Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 11:25 PM read, [Resident #1's last name] has continued to call 911 since I arrived this afternoon. They are loading him up & transporting him, [Resident #1's full name]. Review of Resident #1 medical record did not contain any documentation of the test message communication between the facility and the OCMD. Review of Resident #1's Interact SBAR (Situation, Background, Assessment, Recommendations) Communication form documented by Staff A, LPN, dated 10/6/2024 at 11:25 PM read, Situation: the change in condition (CIC) reported on this CIC evaluation are: other change in condition. At the time of evaluation patient vital signs, weight and blood sugar were blood pressure 130/77, pulse 82, temperature 98.2, pulse oximetry 96% on room air, blood glucose of 552 obtained at 6:45 AM on 10/06/24. Outcomes of physical assessment: positive findings reported were mental status evaluation with no change observed. Functional status evaluation with no changes observed. Patient called 911 on his personal cell phone and stated, I want out of this place. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: No new orders given at this time. Review of Resident #1's medical record did not contain any documentation of further blood glucose checks after the glucose level of 552 was documented at approximately 6:00 AM. Review of the hospital ED (Emergency Department) provider notes for Resident #1 dated 10/6/2024 at 11:51 PM read, Chief complaint: Patient presents with high blood sugar. Patient is an 81 y.o. [year old] M [male] with a PMH [Past Medical History] of oropharyngeal SCC [squamous cell cancer of throat], DVT [Deep Vein Thrombosis], PVD [Peripheral Vascular Disease], T1D [Type 1 Diabetes], HTN [Hypertension], and osteomyelitis who presents from an outside rehab after having unreadable glucose levels on his monitor. He states that at the outside rehab were not following his strict insulin regimen trying to give a different type of insulin. Per EMS [Emergency Medical Services] he was declining the insulin the outside rehab was trying to give him. He was recently admitted on ,d+[DATE] for pneumonia and was discharged to rehab NPO [nothing by mouth] with swallow study pending (gastrostomy tube in place). BASIC METABOLIC PANEL - Abnormal; Notable for the following components: Glucose 745, Anion Gap 34. Medical Evaluation Initiated: Attestation: The patient is critical due to DKA [Diabetic Ketoacidosis]. admitted to the ICU [Intensive Care Unit]. Review of the hospital history and physical for Resident #1 dated 10/7/2024 read, HPI [history of presenting illness]: [Resident #1's name] is an 81 y.o. male presented with hyperglycemia at rehab admitted for DKA. PMH relevant for T1DM (Type 1 Diabetes Mellitus), HTN, oropharyngeal squamous cell carcinoma, peripheral vascular disease, DVT (04/2022) and below the knee amputation secondary to osteomyelitis. Patient reports lack of compliance with his long-term insulin regimen for DM1 [Type 1 Diabetes Mellitus] at his rehab facility. He reports they weren't giving me the right insulin and explains some of the doses of his regimen were being missed. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/13/2024 at 9:25 AM, the Director of Nursing (DON) stated, I was not here for the incident, I found out after I returned that Tuesday. That was the 8th [10/8/2024]. With a blood sugar that high the nurse should have notified the doctor that he [Resident #1] was refusing his insulin and why he was refusing it. The nurse in charge of his care was not acting within the professional standards of practice for treating hyperglycemia in a type 1 diabetic. He [Staff A, LPN] should have notified the doctor immediately when he [Resident #1] refused his insulin. He [Staff A, LPN] did not transcribe the orders, and he should have stayed and transcribed the orders he got. The nurse got the high blood sugar and spoke to someone. I don't know who he spoke with, I don't know their name, you will have to ask [the Administrator's name] and got new orders. I don't know if or what he told the nurse that came on in the day shift. I don't know what the day shift nurse did after that. This shouldn't have happened; this should have been avoided. The nurse that admitted him should have read everything when it comes to the discharge summary, and they would have seen all the other orders instead of just the one piece of paper. The blood sugar should have been rechecked. It was not rechecked the rest of the day. I would consider this neglect. I don't know why the abuse and neglect policies were not followed. We should have completed a RCA [root cause analysis] and we should have implemented the abuse policy and procedure back on the 7th [10/7/2024]. During an interview on 11/13/2024 at 2:49 PM, Staff D, LPN, Unit Manager, stated, I found out [about incident] when his daughter called me, she called on that Monday [10/7/2024]. She was upset about him not getting his insulin and about what happened, this was after he went to the hospital. She said she was a nurse and couldn't understand how we could make a mistake like this. She was very upset about it. She was upset that he was not given his proper insulin and that he was now in Diabetic ketoacidosis. I told [The Administrator's name]. During an interview on 11/13/2024 at 3:18 PM, the Administrator stated, I found out about the situation when I returned to work. I was finally able to speak with the daughter on 10/20/2024. I didn't file a report on 10/7/2024 because we saw on the chart that they only had orders for Lantus, we didn't think it was an issue until he started refusing the medication. The report should have been done, that is the best practice. [Staff A, LPN's name] got the order. It was not placed in [name of the electronic medical record software]. We investigated and did a QAPI [Quality Assurance and Process Improvement] Ad hoc [from Latin meaning for this] meeting on 10/7/2024. I talked to [Staff B's name], she said that the resident refused medications and [Staff A's name] spoke to the nurse practitioner and got orders. The nurse forgot to transcribe the orders into [name of the electronic medical record software]. There was no documentation in [name of the electronic medical record software]. During an interview on 11/13/2024 at 3:43 PM, Staff B, LPN, stated, I did take care of this resident [Resident #1]. He did not refuse care when I took care of him. I was told by the night nurse [Staff A, LPN] that his blood sugar was high. I don't remember him telling me what the blood sugar was, he just said it was high. He did not refuse care that day. I did not try to get another accucheck, he didn't have orders to recheck his blood sugar. I didn't have orders to recheck the blood sugar. I wasn't told how high the blood sugar was. I did not ask how high it was. I was in the front [area of building] charting and apparently, he called 911. I was called and asked if he needed help, I told them [EMS] no, I would check on him. I went to the room, and he said, You are trying to kill me. I asked him why and he told me that 'his blood sugar, his insulin was wrong, and he needed to get short acting insulin, and we weren't ordering it for him. I told him that he had orders for long-acting insulin and that he refused to take it. He told me Yes, I do, but because I need short acting insulin I need to get out of here and you all are trying to kill me. This could have been avoided, I should have rechecked his blood sugar, I don't know why I didn't. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 11/14/2024 at 11:20 AM, the Medical Director stated, I remember a few things because I know the facility felt bad about the whole thing, you know while this was all happening. So, they had called me about it I think this happened over the weekend to my understanding. I know that there was also some frustration on the patient end I think they refused some glucose checks or refused insulin and then at that point I think they called 911. My expectations would be to 100% ensure that there's glucose monitoring, accuchecks, and of course a sliding scale. I mean every single diabetic in the building should be on a sliding scale. I think it was [the OCMD's name] that was notified. I think they went up on the long acting and they were just assuming that the patient was on a sliding scale. 100% if you're in the five hundreds [blood glucose level] and they're on long acting they need to be on a sliding scale, likely in the highest level of the sliding scale you know from there we could go up on the long acting and ensure there's proper glucose monitoring. I would probably give a onetime dose of a short acting and have them recheck sugars in an hour so I'm not sure what took place in this case or how long after that reading the patient called 911. I would want to be notified that they [resident] were refusing [medications]. I don't know if that call was ever made, after the fact, to let the doctor know that he's refusing it. If any doctor's increasing long-acting insulin, they're already assuming that the short acting is on the MAR. During an interview on 11/14/2024 at 7:10 AM, the DON stated, I was not here the day that this was found, that they spoke with his daughter, the Unit Manager spoke to her. They did know the concerns with not providing insulin or ADL [Activities of Daily Living] care. We were still investigating it; I can't tell you why we didn't investigate more. I knew his blood sugar was 552. I was given that information, but I thought it was that [Staff A's name] didn't transcribe orders. I guess we did not do a thorough investigation, I can't find any more than what was done initially and in the town hall meeting. I see that there were more than 12 hours that the resident was still here after that blood sugar of 552. There are no other accuchecks done after that. It is my expectation that staff provide a detailed report when going off their shift. The nurse [Staff A, LPN] should have told [Staff B's name] what the blood sugar was, and he [Staff A, LPN] should have documented his information in the notes. [Staff A's name] should have asked what high meant if that is what he told her. She should have followed up on that. I would expect that she called the doctor again and get further orders. She [Staff B] had the opportunity to call the doctor when he called 911 to get further orders. All the information should have been put in a progress note from both nurses. I would consider this neglect for both nurses. I don't know why the staff weren't suspended; I can't give you a reason. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/14/2024 at 4:10 PM, the Administrator stated, I can't say that I thought I needed to complete a federal report. I was told by [Staff D's name] that she [Resident #1's daughter] was upset and wanted to talk to us, but I wasn't able to connect with her. We attempted multiple times, but we couldn't reach her and left messages. When we got [in touch with] her is when I found out about her concerns with care related to the insulin and with being on the bedpan too long. We did do a QAPI on 10/7 related to the insulin. I just thought it was because he refused to take his insulin. I guess we did not investigate fully until after I spoke to his daughter. We thought the problem was that the nurse on admission got the right orders and there weren't accuchecks ordered. He refused this medication, and I spoke to [Staff B's name], LPN, and she told me that he [Resident #1] didn't talk to her at all about his insulin during the day before he called 911. Then they realized that he had orders that were not transcribed from the night nurse when he came on shift. I did not talk to him [Staff A, LPN] the DON did. I did not implement the abuse and neglect policies because he refused his medication. I didn't think to. I can't tell you why. We should have done more investigation. We should have done a QAPI when we realized that his blood sugar was so high, I wasn't aware of everything. We only did the initial QAPI, we didn't do any others, I think we should have done it, I can't tell you why we didn't. We did not suspend the nurses; it is our policy to suspend staff pending the results of an investigation. We initially thought it happened because the resident refused his insulin, not for neglect. We should follow our abuse and neglect policies and procedures. I didn't think to. I can't tell you why. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the policy and procedure titled Abuse, Neglect, Exploitation & Misappropriation last revision date of 11/16/2022, last approval date of 4/23/2024 read, Policy: It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies and procedures to protect these rights to establish a disciplinary policy which results in a fair and timely treatment of occurrences of resident abuse. Employees at the center are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment, and/or misappropriation of property. No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and or misappropriation of property against any resident. Violation of this standard will subject employees to disciplinary action including dismissal provided herein. Definitions: Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Procedure: 4. Identification: All reported events (bruises, skin tears, falls, inappropriate or abusive behaviors) will be investigated by the Director of Nursing/designee. Patterns or trends will be identified that might constitute abuse. This information will be forwarded to the Executive Director, who will serve as the facility's Abuse Coordinator, and an abuse investigation will be conducted in the absence of the Executive Director, the Director of Nursing will serve as the Abuse Coordinator. 5. Investigation: The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A Social Service representative may be offered in the role of resident advocate during a questioning of or interviewing of residents. Investigations will be accomplished in the following manner. Preliminary Investigation: Immediately upon an allegation of abuse or neglect, the suspect(s) should be segregated from residents pending the investigation of the resident allegation. The nurse or Director of Nursing/designee shall perform and document a thorough nursing evaluation and notify the attending physician. An incident report shall be filed by the individual in charge who received the report in conjunction with the person who reported the abuse. This report shall be filed as soon as possible in order to provide the most accurate information in a timely fashion and submitted to the Abuse Coordinator. Investigation: The Abuse Coordinator and/or Director of Nursing shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared. 6. Protection: Any suspect(s), who is employed or contract service provider, once he/she has(have) been identified, will be suspended pending the investigation. 7. Reporting/ Response: Any employee or contracted service provider who witnesses or has knowledge of an act of abuse or alleged allegation of abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property, to a resident is obligated to report such information immediately but no later than two hours after the allegation is made if the events that caused the allegation involve abuse or resulted in serious bodily injury for not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the administrator and to other officials in accordance with state law. In the absence of the executive director, the director of nursing is designated abuse coordinator. Once an allegation of abuse is reported, the executive director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with federal and state regulations, including notification of law enforcement if a reasonable suspicion of crime has occurred. Facility staff should be aware of and comply with their individual requirements and responsibilities for reporting as required by law. Staff should be aware of, and comply with, individual requirements and responsibilities for reporting as may be required by law. In all cases, the executive director or director of nursing will ensure notification to the residents' legal guardian, family member, responsible party, or significant other of the alleged, suspected or observed abuse, neglect or mistreatment, and the resident's attending physician. Coordination with QAPI: The center will review allegations of abuse, neglect, and misappropriation of resident property and exploitation during QAPI meetings. QAPI committee will review information including but not limited to: The thoroughness of the investigation, Protection of the resident(s), Risk factors identified, Root- cause analysis of the investigation, Systemic changes that may be required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105460	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at North Florida	6700 NW 10th Place Gainesville, FL 32605

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the policy and procedure titled Notification of Change of Condition last revision date of 12/16/2020 and last approval date of 4/23/2024 read, Policy: The Center 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 an accident, significant change in the patient residence physical, mental or psychosocial status, need to alter treatment significantly new treatment, discontinuation of current treatment due to but not limited to adverse consequences acute condition exacerbation of a chronic condition, a trans [TRUNCATED]

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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** 49444 Based on record review, interview, and review of policy and procedure, the facility failed to safeguard medical record information against unauthorized use, failed to maintain complete and accurate medical records, and failed to ensure the confidentiality of the medical record for 1 of 7 residents reviewed, Resident #1. Findings include: Review of the Admission Record for Resident #1 documented an admitted [DATE] with diagnoses that include diabetes mellitus type 1, malignant neoplasm of oropharynx (cancer), unspecified dysphagia (unable to swallow), oropharyngeal phase, type 1 diabetes mellitus without complications, chronic pulmonary embolism (a blockage in a lung artery caused by a blood clot that has traveled from elsewhere in the body), chronic kidney disease, unspecified, other acute osteomyelitis (bone infection), unspecified site, acquired absence of left leg (below knee), essential primary hypertension (high blood pressure), gastrostomy status (a flexible tube that's surgically inserted into the stomach through the abdominal wall. It allows for the delivery of nutrition, fluids, and medication directly into the stomach), hyperlipidemia, unspecified (an abnormally high concentration of fats or lipids in the blood), peripheral vascular disease, unspecified (blood vessels narrow or become blocked, reducing blood flow to the limbs or other parts of the body). Review of Resident #1's physician order dated 10/4/2024 read, Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 10 units subcutaneously one time a day related to Type 1 Diabetes Mellitus Without Complications. Review of Resident #1's Medication Administration Record (MAR) showed Staff A, Licensed Practical Nurse (LPN), documented a BS (blood sugar) of 552 on 10/6/2024 at 6:00 AM. Staff A, LPN, documented 2, CM (chart code/follow up codes 2 = drug refused). Review of Resident #1's eMAR (electronic Medication Administration Record) note dated 10/6/2024 at 6:32 AM documented by Staff A, LPN, read, Patient stated, I'm refusing all medications until I get the proper insulin. Review of Resident #1's progress note dated 10/6/2024 at 7:00 AM documented by Staff A, LPN, read, ARNP [Advanced Registered Nurse Practitioner] notified of resident's refusal of all morning medications. Per resident he is refusing all medications until he is receiving the proper insulin. Orders received to increase current insulin twice daily with blood sugars checked twice daily. No other orders given at this current time. Review of text message communication from Staff A, LPN's personal cellular phone to the On Call Medical Doctor (OCMD) on 10/6/2024 at 7:33 AM read, Good Morning, [Resident #1's name] is refusing all of his medications. He says he's not taking anything until he receives the proper insulin. Per his orders he's receiving 10 Units of Lantus @ [at] 6 am. He did allow me to check his blood sugar 552. (continued on next page)

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	105460	A. Building B. Wing	11/19/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of text message communication from the OCMD to Staff A, LPN's personal cellular phone on 10/6/2024 at 8:19 AM read, No sliding scale ordered? Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 8:22 AM read, No, I didn't see any sliding scale he said his Lantus is supposed to be given @ night. And he has another type of insulin he gets. I didn't see anything other than the Lantus. Review of text message communication from the OCMD to Staff A, LPN's personal cellular phone on 10/6/2024 at 10:55 AM read, Based on his sugars, if they have been above 250 everyday, go up to 15 BID [15 units two times a day] of long-acting insulin and make sure we cover with sliding scale for meals. Let's also make sure he's getting accuchecks. Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 7:55 PM read, I'll change his orders & notify him of the changes & hopefully he complies. Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 11:25 PM read, [Resident #1's last name] has continued to call 911 since I arrived this afternoon. They are loading him up & transporting him, [Resident #1's full name]. Review of Resident #1's medical record showed no orders in the electronic medical record for the orders from the OCMD. Review of Resident #1's medical record showed no entries related to the text message communications of the physician notification or orders. Review of Resident #1's medical record showed no progress notes documented by Staff B, LPN, of the EMS (Emergency Medical Services) calls or inaction with the resident at approximately 6:30 PM. During a telephone interview on 11/13/2024 at 11:35 AM, the OCMD stated, I did receive a call related to this resident [Resident #1]. The Nurse called me on the afterhours line, and I was told of the residents' glucose and I actually decided to double the insulin, the Lantus, and increase it to 15 Units twice a day and to add SSIC [Sliding Scale Insulin Coverage] with insulin coverage AC [before meals] and HS [at bedtime]. I would say that the professional standard of practice would be to have the blood glucose rechecked after 30 minutes to one hour after high readings to accurately assess if the patient was stabilizing versus the patient needing further emergency treatment. The staff did not adhere to a professional standard of practice when they did not notify us that he was refusing treatment. I would expect staff to inform us that a patient had refused insulin to determine the next steps we needed to do, either increase medications or we send to the hospital. I would call this unintentional neglect. They did not treat this according to professional standards of practice. I should have been notified that the patient was refusing his insulin. I was not called about this again after I gave the orders to them. This was done by a text message thread. We use a HIPAA [Health Insurance Portability and Accountability Act] complaint application, but I do not know what the facility uses. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/2024 at 2:09 PM, the Administrator stated, I am aware that staff use their cell phones to communicate with the providers, the preferred method of communication is a telephone call, but they still do use their cell phones. There was resident information in the text messages. I don't know if we have a policy on cell phone usage. It would be a HIPAA violation if they provide PHI [Personal Health Information]. PHI was in the text thread. During an interview on 11/14/2024 at 2:15 PM, the Director of Nursing (DON) stated, I had this text thread during our investigation. The ARNP [Advanced Registered Nurse Practitioner] sent us copies of the communication the next day. During an interview on 11/14/2024 at 4:15 PM, Staff E, LPN, stated, We sometimes will use our personal cell phones to contact the doctor regarding the care of the residents. I do not have the messages on the phone, I delete them after. I would use the facility phone to try and reach the doctor. During an interview on 11/14/2024 at 4:20 PM, Staff F, LPN, stated, We would use our cell phones to communicate with the doctor if the facility phone was not working or in the case of an emergency. I do not have those text messages on my phone, I delete them. During an interview on 11/14/2024 at 4:28 PM, Staff Q, LPN, stated, I would use my cell phone sometimes. I would not have any personal health information in the body of the message I would use room numbers because they can look up the resident. I use the phone mostly because it provides the fastest result. During an interview on 11/15/2024 at 6:15 AM, Staff R, LPN, stated, We text to get orders if we need to. I use my cell phone to do that, no they don't have a company phone we use; we use our own phones. I will text that the resident has a problem, I do use their name and say what is happening, I will keep it on my phone for about 2 weeks and then I will delete the messages. During an interview on 11/15/2024 at 6:25 AM, Staff S, LPN, stated, I do text the doctors or the nurse practitioner to get orders or tell them about changes or if I need something. I do use my own telephone. I do put in a residents' name, we can't use room numbers as a identifier, it's always a name. I do delete it after I get the order and put in [name of the electronic medical record software]. During an interview on 11/15/2024 at 6:36 AM, Staff T, LPN, stated, I do use text messages to the on-call doctor with my cell phone. They don't always call back, it's easier to text them and get an answer. I would say whatever was happening with the resident. Of course, I identify them [residents] by name we can't use anything else. During an interview on 11/15/2024 at 12:10 PM, the Administrator stated, Our policies on cell phone use don't allow staff to use their personal cell phones. It could be a problem. I would expect staff might use their cell phone to reach out to the providers via text to have them give them a call. I do not feel that is appropriate to exchange PHI. We did identify we did have a text thread with information in it. I can't say why we didn't look deeper into this. (continued on next page)

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	105460	A. Building B. Wing	11/19/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/2024 at 12:10 PM, the DON stated, Using and putting a resident's personal information on employees personal cell phones is problematic. We do know that personal text messages are never totally gone even if they are deleted. I would say residents could be upset if they knew this. We should not put any PHI in a text message. I'm not sure what the policy says directly. It is a resident right to have their information confidential. During an interview on 11/15/2024 at 12:50 PM, the APRN stated, The nurses are using text messages to communicate with me, they use identifiers on text communication such as room number and initials sometimes I might get just the first name just the last name sometimes I get both first and last names. During an interview on 11/15/2024 at 12:55 PM, the OCMD stated, The staff would use three digits either in letters or a room number and give us an update and if it's something that needs clarification. The communication goes through a [name of the application]. I don't know how they do it locally I just know that we have a number that we get messages. I have been provided first and last names of residents, room numbers also over the texts sent by the nurses. I don't know what they use to text us with. During an interview on 11/15/2024 at 1:10 PM, the Medical Director stated, The staff will text us from unknown numbers We're just getting a request and handling it to make sure the patients are getting what they need. They will provide us resident names. During an interview on 11/15/2024 at 3:10 PM, Staff J, LPN, stated, I used to text or call [the ARNP's name] all the time, she would always respond to me and give me orders. I would delete the messages a few days later and some I may have had deleted after a month or so. I would make sure the orders were in and were followed. I would document the interaction with the physician or the nurse practitioner and place the order for the resident. During an interview on 11/15/2024 at 3:30 PM, Staff B, LPN, stated, We do use our cell phones to get hold of the nurse practitioner. I do use my own personal cell phone. Well, the only way I can identify a resident is by name. I will also use a room number too, but the name also. I do have the zoom app on my telephone [did show us this app was on her telephone], I don't use this to do text messages. We use this for a face-to-face communication with the resident. The provider will give us a number and we have a zoom with the resident. I will delete the texts after I write any orders. No one ever told us we couldn't text on our phones. During an interview on 11/18/2024 at 7:00 AM, Staff U, LPN, stated, I did use my cell phone to text the on call [provider] with my own phone. I did identify who the resident was I was texting about. During an interview on 11/18/2024 at 7:10 AM, Staff V, LPN, stated, I was texting with my cell phone, but only when I couldn't get them (the provider) on the phone, I did have times when I used a residents name, their full name. I wouldn't use just a room number because what if we moved them somewhere else. (continued on next page)

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	105460	A. Building B. Wing	11/19/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy and procedure titled Use of Cellular Phones and Personal Electronic Devices with the revision date of 9/1/2017 and the last approval date of 4/23/2024 read, Policy: In order to maintain privacy and confidentiality rights of our residents, to be in compliance with HIPAA and to attain an acceptable noise level for our residents, the use of any non-company issued personal electronic device, such as cellular telephones, pagers, tablets, or any other personal electronic device is prohibited in resident areas. Procedure: 1. Employees are not allowed to use personal cellular phones or electronic devices in resident areas, at any time . 3. HIPAA Protected Health Information (PHI) should never be stored, shared, or accessed on a personal device. a. Inappropriate use of a cellular device by an employee includes, but is not limited to, photographing or videoing residents, sharing HIPAA protected information via unsecured networks such as text message, or electronically sharing resident information that does not meet the minimum necessary standard on a personal or company device. Review of the facility policy and procedure titled Complaint text Messaging Communication with the revision date of 3/1/2022 and the last approval date of 4/23/2024 read, Policy: It is the policy of the Company to maintain the privacy and confidentiality of resident Protected Health Information (PHI) and electronic PHI (ePHI) in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of this policy is to establish guidance on short message service (SMS) text messaging by members of the Company's workforce and address the security risks associated with the transmission of ePHI via unsecured network. Definitions . Personal Electronic Device- Electronic devices, capable of communications, data processing and/or computing. Examples are laptops, computers, tablets, e-readers, smartphones, MP3 players, [NAME] and electronic toys. Protected Health Information (PHI)- Individually identifiable health information is information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. It is information, including demographic data that relates to: (1) the individual's past, present, or future physical or mental health or condition, (2) the provision of health care to the individual, or (3) the past present or future payment for the provision of health care to the individual, and that identifies the individual for which there is a reasonable basis to believe it can be used to identify the individual . SMS text messaging maybe used to communicate with your coworkers, supervisors, partners or vendors for reasons that do not include the transmission of PHI or where PHI had then de-identified in compliance with company policy HIPAA- 135 and the HIPAA administrative regulations 45 CFR 164.514 and there is no reasonable basis to believe that the information can be used to identify an individual. Review of the facility policy and procedure titled Clinical/Medical records with the last revision date of 8/25/2017 and the last approval date of 4/23/2024 read, Policy: Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care. The purpose of the clinical record is to document the course of the resident's plan of care and to provide a medium of communication among health care professionals involved in this care. The clinical record contains: information to identify the resident, a record of the resident's assessments, the plan of care, the results of preadmission screening, progress notes which indicate change toward achieving the care plan objectives. Information contained in the resident's clinical record, regardless of the form of storage method is considered confidential. (continued on next page)

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	105460	A. Building B. Wing	11/19/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Admission Agreement showed the agreement contained a form on page 9 titled Notification & Consent Form, which read, Patient Authorization And Consent Form For Disclosure Of Health Information. Page 10 of the agreement read, Definitions: In this form, the term treatment, healthcare operations, psychotherapy notes, and protected health information are as defined in HIPAA (45 CFR 164.501). A health information exchange is in interoperable system that electronically moves and exchanges health information between approved participating healthcare providers or health information organizations in a manner that ensures the secure exchange of health information to provide care to patients . Privacy protection: Participants in an exchange must follow all applicable federal and state privacy laws, including the federal Health Insurance Portability and Accountability Act and the Health Information Technology for Economic and Clinical Health Act, in addition to other related regulations. Further review of the agreement read, Notice of Privacy Practices: This notice describes how medical information about you may be used and disclosed and how you can get access to this information please read it carefully. We have summarized our responsibilities and your rights on this page for a complete description of our privacy practices, please contact the Facility Privacy Director (Executive Director). Our responsibilities: Our nursing facility is required to maintain the privacy of your health information, provide you with this notice of our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49444 Based on interview and record review, the facility failed to utilize the Quality Assessment and Performance Improvement (QAPI) process to investigate, develop, and implement an effective performance improvement plan (PIP) when investigating neglect, change of condition, notification of providers and not following physician orders for Resident #1, placing all 27 residents who were prescribed long and short acting insulin at risk. On 10/6/2024 at 6:00 AM, Resident #1 had a blood sugar value of 552 and the on-call provider was notified of the value and the resident stated he was refusing medications until he received the proper insulin. Staff A, Licensed Practical Nurse, (LPN), did not communicate to Staff B, LPN or transcribe the new orders into the medical record for the increase in insulin and the addition of sliding scale insulin coverage. Staff B, LPN, assumed care of Resident #1 at 7:00 AM on 10/6/2024 and did not follow up with the provider. Staff B, LPN, did not reassess Resident #1's blood glucose or address the need for any orders. Resident #1 called 911 at approximately 6:30 PM, Emergency Medical Services (EMS) contacted the facility, spoke with Staff B, LPN, who instructed EMS the resident did not need help. Again at 11:15 PM, Resident #1 called 911 and was subsequently transferred to the hospital and was admitted to the Intensive Care Unit with a diagnosis of Diabetic Ketoacidosis. The facility's failure to develop and implement appropriate plans of actions after identifying the systemic breakdown for failure to implement policy and procedures for neglect and change of condition led to a determination of Immediate Jeopardy at a scope and severity of isolated (J). The Nursing Home Administrator was notified of the Immediate Jeopardy on November 18, 2024, at 2:50 PM. The Immediate Jeopardy began on October 6, 2024, and was removed on site on November 18, 2024. Findings include: Review of the Admission Record for Resident #1 documented an admitted [DATE] with diagnoses that include diabetes mellitus type 1, malignant neoplasm of oropharynx (cancer), unspecified dysphagia (unable to swallow), oropharyngeal phase, type 1 diabetes mellitus without complications, chronic pulmonary embolism (a blockage in a lung artery caused by a blood clot that has traveled from elsewhere in the body), chronic kidney disease, unspecified, other acute osteomyelitis (bone infection), unspecified site, acquired absence of left leg (below knee), essential primary hypertension (high blood pressure), gastrostomy status (a flexible tube that's surgically inserted into the stomach through the abdominal wall. It allows for the delivery of nutrition, fluids, and medication directly into the stomach), hyperlipidemia, unspecified (an abnormally high concentration of fats or lipids in the blood), peripheral vascular disease, unspecified (blood vessels narrow or become blocked, reducing blood flow to the limbs or other parts of the body). Review of Resident #1's physician order dated 10/4/2024 read, Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 10 units subcutaneously one time a day related to Type 1 Diabetes Mellitus Without Complications. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Medication Administration Record (MAR) showed Staff A, LPN, documented a BS (blood sugar) of 552 on 10/6/2024 at 6:00 AM. Staff A, LPN, documented 2, CM (chart code/follow up codes 2 = drug refused). Review of Resident #1's eMAR (electronic Medication Administration Record) note dated 10/6/2024 at 6:32 AM documented by Staff A, LPN, read, Patient stated, I'm refusing all medications until I get the proper insulin. Review of Resident #1's progress note dated 10/6/2024 at 7:00 AM documented by Staff A, LPN, read, ARNP [Advanced Registered Nurse Practitioner] notified of resident's refusal of all morning medications. Per resident he is refusing all medications until he is receiving the proper insulin. Orders received to increase current insulin twice daily with blood sugars checked twice daily. No other orders given at this current time. Review of text message communication from Staff A, LPN's personal cellular phone to the On Call Medical Doctor (OCMD) on 10/6/2024 at 7:33 AM read, Good Morning, [Resident #1's name] is refusing all of his medications. He says he's not taking anything until he receives the proper insulin. Per his orders he's receiving 10 Units of Lantus @ [at] 6 am. He did allow me to check his blood sugar 552. Review of text message communication from the OCMD to Staff A, LPN's personal cellular phone on 10/6/2024 at 8:19 AM read, No sliding scale ordered? Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 8:22 AM read, No, I didn't see any sliding scale he said his Lantus is supposed to be given @ night. And he has another type of insulin he gets. I didn't see anything other than the Lantus. Review of text message communication from the OCMD to Staff A, LPN's personal cellular phone on 10/6/2024 at 10:55 AM read, Based on his sugars, if they have been above 250 everyday, go up to 15 BID [15 units two times a day] of long-acting insulin and make sure we cover with sliding scale for meals. Let's also make sure he's getting accuchecks. Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 7:55 PM read, I'll change his orders & notify him of the changes & hopefully he complies. Review of text message communication from Staff A, LPN's personal cellular phone to the OCMD on 10/6/2024 at 11:25 PM read, [Resident #1's last name] has continued to call 911 since I arrived this afternoon. They are loading him up & transporting him, [Resident #1's full name]. Review of Resident #1 medical record did not contain any documentation of the test message communication between the facility and the OCMD. (continued on next page)

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	105460	A. Building B. Wing	11/19/2024

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Interact SBAR (Situation, Background, Assessment, Recommendations) Communication form documented by Staff A, LPN, dated 10/6/2024 at 11:25 PM read, Situation: the change in condition (CIC) reported on this CIC evaluation are: other change in condition. At the time of evaluation patient vital signs, weight and blood sugar were blood pressure 130/77, pulse 82, temperature 98.2, pulse oximetry 96% on room air, blood glucose of 552 obtained at 6:45 AM on 10/06/24. Outcomes of physical assessment: positive findings reported were mental status evaluation with no change observed. Functional status evaluation with no changes observed. Patient called 911 on his personal cell phone and stated, I want out of this place. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: No new orders given at this time. Review of Resident #1's medical record did not contain any documentation of further blood glucose checks after the glucose level of 552 was documented at approximately 6:00 AM. Review of the hospital ED (Emergency Department) provider notes for Resident #1 dated 10/6/2024 at 11:51 PM read, Chief complaint: Patient presents with high blood sugar. Patient is an 81 y.o. [year old] M [male] with a PMH [Past Medical History] of oropharyngeal SCC [squamous cell cancer of throat], DVT [Deep Vein Thrombosis], PVD [Peripheral Vascular Disease], T1D [Type 1 Diabetes], HTN [Hypertension], and osteomyelitis who presents from an outside rehab after having unreadable glucose levels on his monitor. He states that at the outside rehab were not following his strict insulin regimen trying to give a different type of insulin. Per EMS [Emergency Medical Services] he was declining the insulin the outside rehab was trying to give him. He was recently admitted on ,d+[DATE] for pneumonia and was discharged to rehab NPO [nothing by mouth] with swallow study pending (gastrostomy tube in place). BASIC METABOLIC PANEL - Abnormal; Notable for the following components: Glucose 745, Anion Gap 34. Medical Evaluation Initiated: Attestation: The patient is critical due to DKA [Diabetic Ketoacidosis]. admitted to the ICU [Intensive Care Unit]. Review of the document titled Ad Hoc Quality Assurance & Performance Improvement Meeting dated 10/7/2024 attended and signed by the Administrator, Social Services Director, MDS Coordinator, Housekeeping/Laundry, Business Office, the DON, Activities, Therapy, Medical Director, Dining/Nutrition and 4 other attendees with no job title, read, Reason for Meeting: Type 1 & 2 diabetes. Opportunity for Improvement: Notification of Type 1 and Type 2 diabetes upon admission with NP/MD [Nurse Practitioner/Medical Doctor] to ensure insulin orders are verified and correct to decrease delayed treatment. Data (Assess Current Situation- What were the results/trend): Failure to notify provider with type 1 diabetic glucose monitoring results in a timely manner. Analysis (Root Cause analysis): Failure to notify provider related to abnormal glucose levels, failure follows transcribe orders from provider to [name of the electronic medical record software]. Plan: Key staff to be educated on type 1 and type 2 diabetes and when to notify NP/MD. Parameters when notifying provider. Audits for all new admits/resident with diabetic dx [diagnosis] to be reviewed in the clinical meeting daily. Review on next monthly QAPI meeting. Responsible Team Members(s): DCS [Director of Clinical Services]/designee, ADCS [Assistant Director of Clinical Services]/designee, UM [Unit Manager), IDT [Interdisciplinary Team]. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/13/2024 at 9:25 AM, the Director of Nursing (DON) stated, I was not here for the incident, I found out after I returned that Tuesday. That was the 8th [10/8/2024]. With a blood sugar that high the nurse should have notified the doctor that he [Resident #1] was refusing his insulin and why he was refusing it. The nurse in charge of his care was not acting within the professional standards of practice for treating hyperglycemia in a type 1 diabetic. He [Staff A, LPN] should have notified the doctor immediately when he [Resident #1] refused his insulin. He [Staff A, LPN] did not transcribe the orders, and he should have stayed and transcribed the orders he got. The nurse got the high blood sugar and spoke to someone. I don't know who he spoke with, I don't know their name, you will have to ask [the Administrator's name] and got new orders. I don't know if or what he told the nurse that came on in the day shift. I don't know what the day shift nurse did after that. This shouldn't have happened; this should have been avoided. The nurse that admitted him should have read everything when it comes to the discharge summary, and they would have seen all the other orders instead of just the one piece of paper. The blood sugar should have been rechecked. It was not rechecked the rest of the day. I would consider this neglect. I don't know why the abuse and neglect policies were not followed. We should have completed a RCA [root cause analysis] and we should have implemented the abuse policy and procedure back on the 7th [10/7/2024]. During an interview on 11/13/2024 at 2:49 PM, Staff D, LPN, Unit Manager, stated, I found out [about incident] when his daughter called me, she called on that Monday [10/7/2024]. She was upset about him not getting his insulin and about what happened, this was after he went to the hospital. She said she was a nurse and couldn't understand how we could make a mistake like this. She was very upset about it. She was upset that he was not given his proper insulin and that he was now in Diabetic Ketoacidosis. I told [The Administrator's name]. During an interview on 11/13/2024 at 3:18 PM, the Administrator stated, I found out about the situation when I returned to work. I was finally able to speak with the daughter on 10/20/2024. I didn't file a report on 10/7/2024 because we saw on the chart that they only had orders for Lantus, we didn't think it was an issue until he started refusing the medication. The report should have been done, that is the best practice. [Staff A, LPN's name] got the order. It was not placed in [name of the electronic medical record software]. We investigated and did a QAPI Ad hoc [from Latin meaning for this] meeting on 10/7/2024. I talked to [Staff B's name], she said that the resident refused medications and [Staff A's name] spoke to the nurse practitioner and got orders. The nurse forgot to transcribe the orders into [name of the electronic medical record software]. There was no documentation in [name of the electronic medical record software]. During an interview on 11/13/2024 at 3:43 PM, Staff B, LPN, stated, I did take care of this resident [Resident #1]. He did not refuse care when I took care of him. I was told by the night nurse [Staff A, LPN] that his blood sugar was high. I don't remember him telling me what the blood sugar was, he just said it was high. He did not refuse care that day. I did not try to get another accucheck, he didn't have orders to recheck his blood sugar. I didn't have orders to recheck the blood sugar. I wasn't told how high the blood sugar was. I did not ask how high it was. I was in the front [area of building] charting and apparently, he called 911. I was called and asked if he needed help, I told them [EMS] no, I would check on him. I went to the room, and he said, You are trying to kill me. I asked him why and he told me that 'his blood sugar, his insulin was wrong, and he needed to get short acting insulin, and we weren't ordering it for him. I told him that he had orders for long-acting insulin and that he refused to take it. He told me Yes, I do, but because I need short acting insulin I need to get out of here and you all are trying to kill me. This could have been avoided, I should have rechecked his blood sugar, I don't know why I didn't. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/14/2024 at 7:10 AM, the DON stated, I was not here the day that this was found, that they spoke with his daughter, the Unit Manager spoke to her. They did know the concerns with not providing insulin or ADL [Activities of Daily Living] care. We were still investigating it; I can't tell you why we didn't investigate more. I knew his blood sugar was 552. I was given that information, but I thought it was that [Staff A's name] didn't transcribe orders. I guess we did not do a thorough investigation, I can't find any more than what was done initially and in the town hall meeting. I see that there were more than 12 hours that the resident was still here after that blood sugar of 552. There are no other accuchecks done after that. It is my expectation that staff provide a detailed report when going off their shift. The nurse [Staff A, LPN] should have told [Staff B's name] what the blood sugar was, and he [Staff A, LPN] should have documented his information in the notes. [Staff A's name] should have asked what high meant if that is what he told her. She should have followed up on that. I would expect that she called the doctor again and get further orders. She [Staff B] had the opportunity to call the doctor when he called 911 to get further orders. All the information should have been put in a progress note from both nurses. I would consider this neglect for both nurses. I don't know why the staff weren't suspended; I can't give you a reason. During an interview on 11/14/2024 at 4:10 PM, the Administrator stated, I can't say that I thought I needed to complete a federal report. I was told by [Staff D's name] that she [Resident #1's daughter] was upset and wanted to talk to us, but I wasn't able to connect with her. We attempted multiple times, but we couldn't reach her and left messages. When we got [in touch with] her is when I found out about her concerns with care related to the insulin and with being on the bedpan too long. We did do a QAPI on 10/7 related to the insulin. I just thought it was because he refused to take his insulin. I guess we did not investigate fully until after I spoke to his daughter. We thought the problem was that the nurse on admission got the right orders and there weren't accuchecks ordered. He refused this medication, and I spoke to [Staff B's name], LPN, and she told me that he [Resident #1] didn't talk to her at all about his insulin during the day before he called 911. Then they realized that he had orders that were not transcribed from the night nurse when he came on shift. I did not talk to him [Staff A, LPN] the DON did. I did not implement the abuse and neglect policies because he refused his medication. I didn't think to. I can't tell you why. We should have done more investigation. We should have done a QAPI when we realized that his blood sugar was so high, I wasn't aware of everything. We only did the initial QAPI, we didn't do any others, I think we should have done it, I can't tell you why we didn't. We did not suspend the nurses; it is our policy to suspend staff pending the results of an investigation. We initially thought it happened because the resident refused his insulin, not for neglect. We should follow our abuse and neglect policies and procedures. I didn't think to. I can't tell you why. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the policy and procedure titled Quality Assurance and Performance Improvement Program (QAPI) last revision date of 10/24/2022 and last approval date of 4/23/2024, read, Policy: The Center and organization has a comprehensive, data-driven quality assurance performance improvement program that focuses on indicators of the outcomes of care and quality of life. Procedure: 1. The center's QAPI program is ongoing comprehensive review of care and services provided to residents. Leadership: The Center Executive Director is accountable for the overall implementation and functioning of the QAPI program. This includes but is not limited to: a). Implementation. b). Identify priorities. c). Ensures adequate resources. d). Ensures performance indicators, resident and staff input and other information is used to prioritize problems and opportunities. e). Ensures corrective actions are implemented to address identified problems in systems. f). Evaluates the effectiveness of actions. g). Establishes expectations for safety, quality, rights, and choice and respect. 5. The quality assessment and assurance committee (QAA) meetings are at least quarterly but may be held more frequently as appropriate. Systemic Analysis and Action: 11. The center will establish and utilize a systemic approach to identify underlying causes of problems, including but not limited to: a. Root cause analysis. b. Failure Mode Effective Analysis. 12. The center will develop corrective actions based on the information gathered and review effectiveness of the actions. 13. The center will review and develop corrective actions on medical errors and adverse events. a. Center obtain and review information on any medical error and adverse event. b. Utilize a systemic approach to identify underlying cause. c. Develop and monitor action plans. Identifying Quality Deficiencies and Corrective Action: The center will monitor department performance systems to identify issues and adverse events. 14. Center will review department system data. 15. If a quality deficiency is identified, the committee will oversee the development of corrective action(s). 16. The center may choose the method of corrective action i.e. 'Plan, Do, Study, Act' or 'Performance Improvement Project.' Performance Improvement Projects: The center utilizes performance improvement projects to improve a systemic problem or improve quality in absence of a problem. Performance Improvement Projects (PIPs) are based on the center services and resources identified in the Facility Assessment. 17. At a minimum, the center must conduct one performance improvement project annually. a). The PIP should focus on high risk or problem prone areas, identified by the center. b). The team may consist of one or more team members. c. The team will complete the following functions: i. Collect and analyze data, ii. Determine Root Cause, iii. Determine steps for resolution, iv. Implement corrective action(s), v. Evaluate the effectiveness of the action(s), vi. Report progress to the QAPI committee. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy (IJ) was removed onsite on 11/18/2024 after the receipt of an acceptable IJ removal plan. The facility has completed the following steps to remove the immediate jeopardy. On 11/15/2024, the Executive Director received education from the Regional [NAME] President on the CMS Five (5) Elements of Quality Assurance Performance Improvement (QA/PI) and reviewed the findings indicating facility failed to identify areas not in compliance regarding the nurse failing to reassess the resident, failed to document the change-in-condition, lack of shift-to-shift report, insulin administration, Abuse and Neglect identification and process, failed to follow policies and procedures when transferring resident to the hospital , and lack of communication between staff and providers. The Executive Director was educated on the Quality Assurance Performance Improvement (QA/PI) process to include education on identifying a problem, starting and completing an investigation, and implementing a Performance Improvement Plan (PIP) and Plan of Correction (POC). The Executive Director was educated on the reporting process of a potential deficient practice to the Quality Assurance Performance Improvement (QA/PI) by notifying the Executive Director and/or Director of Nursing. On 11/18/2024 Key staff (to include the Medical Director, Director of Nursing, Infection preventionist, Wound Care Nurse, Activities Director, Medical Records, Human Resourses, Business Office Mangers, and the Environmental Services Manager) were educated on the CMS Five (5) Elements of Quality Assurance Performance Improvement (QA/PI) and reviewed the findings indicating facility failed to identify areas not in compliance regarding the nurse failing to reassess the resident, failed to document the change-in-condition, lack of shift-to-shift report, insulin administration, Abuse and Neglect identification and process, failed to follow policies and procedures when transferring resident to the hospital , and lack of communication between staff and providers. Key staff were educated on the Quality Assurance Performance Improvement (QA/PI) process to include education on identifying a problem, starting and completing an investigation, and implementing a Performance Improvement Plan (PIP) and Plan of Correction (POC). On 11/18/2024, an Ad Hoc that involved the Executive Director, Medical Director, Director of Nursing identified the root cause analysis was the facility failed to initiate/implement the abuse/neglect policy including a complete investigation. The facility failed to identify areas not in compliance regarding the nurse failing to reassess the resident, failed to document the change-in-condition, lack of shift-to-shift report, insulin administration, Abuse/Neglect identification and process, failed to follow policies and procedures when transferring the resident to the hospital and lack of communication between staff and providers. Review of the facility records documented the Executive Director received education from the Regional [NAME] President on the CMS Five (5) Elements of Quality Assurance Performance Improvement (QA/PI) and reviewed the findings indicating facility failed to identify areas not in compliance regarding the nurse failing to reassess the resident, failed to document the change-in-condition, lack of shift-to-shift report, insulin administration, Abuse and Neglect identification and process, failed to follow policies and procedures when transferring resident to the hospital , and lack of communication between staff and providers. The Executive Director was educated on the Quality Assurance Performance Improvement (QA/PI) process to include education on identifying a problem, starting and completing an investigation, and implementing a Performance Improvement Plan (PIP) and Plan of Correction (POC). The Executive Director was educated on the reporting process of a potential deficient practice to the Quality Assurance Performance Improvement (QA/PI) by notifying the Executive Director and/or Director of Nursing. Review of the Ad Hoc QAPI meeting held on 11/18/2024 that involved the Executive Director, Medical Director, Director of Nursing identified the root cause analysis was the facility failed to initiate/implement the abuse/neglect policy including a complete investigation. (continued on next page)

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