STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105465	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Arbor Springs	1501 SE 24th Rd Ocala, FL 34471

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523 Based on record review and interview, the facility failed to ensure resident assessments accurately reflected each resident's status for 1 of 3 residents reviewed for nutrition, Resident #3. Findings include: Review of Resident #3's annual Minimum Data Set (MDS) dated [DATE] showed the resident was not on a therapeutic diet while a resident at the facility under Section K- Swallowing/Nutritional Status. Review of Resident #3's physician order dated 11/18/2024 read, Regular diet Regular texture, regular/thin consistency, CCD NAS (Controlled Carbohydrate Diet No Added Salt) diet. During an interview on 5/8/2025 at 10:13 AM, the MDS Coordinator stated, [Resident #3's name] MDS will have to be modified to reflect she was on a controlled carbohydrate diet back in November. During an interview on 5/8/2025 at 10:48 AM, the Director of Nursing stated, The MDS should be accurate, reflecting the correct information pertaining to the resident.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41334 Based on observation, interview, and record review, the facility failed to ensure residents received care and services according to professional standards of practice for 2 of 6 residents reviewed for IV (Intravenous) therapy, Residents #6 and #3. Findings include: 1) During an observation on 5/8/2025 at 5:40 AM, Resident #6 was sleeping. The resident had a single lumen midline catheter to her left upper arm, infusing IV fluids. The transparent dressing over the midline insertion site was lifting up at the edges. Under the transparent dressing, there was a gauze that had dried blood on it; occluding the view of the insertion site. The dressing was dated 4/29/2025. Review of Resident #6's physician order dated 4/29/2025 read, Insert midline: May use 1% Lidocaine for IV insertion one time only for IV hydration for one day. Review of Resident #6's physician order dated 5/1/2025, with discontinued date of 5/2/2025 read, Change Left arm midline catheter dressing every week with transparent dressing. Review of Resident #6's medication administration record (MAR) for May 2025 showed no midline catheter dressing changes documented. During an interview on 5/8/2025 at 6:02 AM, Staff E, Registered Nurse (RN), stated, The dressing should have been changed already. I'm not sure why it wasn't. The date on it is 4/29/2025. There is blood and gauze under the dressing that makes it needed to be changed. I'm not sure why it wasn't. During an interview on 5/8/2025 at 7:30 AM, Resident #6 stated, That [the dressing] hasn't been changed at all since I got it put in. It's had blood under that since it was put in. It was bleeding a little when they put it in. I needed to get these IV fluids because my kidneys weren't working so good. During an observation on 5/8/2025 at 10:50 AM, Resident #6 was resting quietly in bed with a left midline with IV fluids infusing. The dressing was dated 4/29/2025 and was pulling up from the skin. There was a 2x2 gauze covered with dried blood under the transparent dressing. During an interview on 5/8/2025 at 12:55 PM, the Director of Nursing (DON) stated, All central line dressings need to be changed every 7 days. If there is gauze under a dressing, it should be changed every 2 days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure titled Catheter Insertion and Care read, Midline dressing changes: Policy: Midline catheter dressings will be changed at specified intervals, or when needed, to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. General Guidelines: 1. Change midline catheter dressing 24 hours after catheter insertion, every 5-7 days, or if it is wet, dirty, not intact, or compromised in any way . 4. Use a sterile, transparent, semi- permeable membrane (TSM) or gauze dressing. If gauze dressing is used, cover the gauze with a TSM dressing and change the dressing every 48 hours. 46523 2) During an interview on 5/8/2025 at 6:28 AM, Resident #3 stated, The staff inserted a midline in my arm by mistake. I did not need the midline for the medication that was prescribed. I even took a picture of the midline. Then the staff had to remove the midline from my arm when they realized the medication was an injection. Review of Resident #3's physician order dated 3/27/2025 read, Ceftriaxone Sodium Intravenous Solution Reconstitued 1 GM [gram] (Ceftriaxone Sodium), Use 1 gram intravenously every 24 hours for infection/abscess for 7 days dilute with 2.1 ml [milliliters] of 1% lidocaine solution. Review of Resident #3's physician order dated 3/27/2025 read, Insert midline IV for Ceftriaxone Sodium Intravenous Solution Reconstituted 1 GM, may us 1% lidocaine STAT for antibiotic use. Review of Resident #3's physician order dated 3/27/2025 read, Ceftriaxone Sodium Solution Reconstitueted 1 GM, Inject 1 gram intramuscularly every 24 hours for infection/abscess for 7 Days Dilute with 2.1 mL of 1% lidocaine solution. Review of Resident #3's Medication Administration Record (MAR) for March 2025 showed midline was inserted on 3/27/2025 at 11:00 PM. Review of Resident #3's MAR for March 2025 showed Ceftriaxone Sodium Injection Solution was administered intramuscularly from 3/28/2025 through 3/31/2025. Review of Resident #3's MAR for April 2025 showed Ceftriaxone Sodium Injection Solution was administered intramuscularly from 4/1/2025 through 4/3/2025. Review of Resident #3 progress note dated 3/27/2025 read, resident need iv (intravenous) access for antibiotics. Review of Resident #3's progress note dated 3/28/2025 read, Received orders to remove pt [patient] midline. Old dressing was removed, site was cleansed with chlorhexidine solution, and allowed to air dry. Midline catheter was gently removed, applying pressure to the insertion site. Catheter tip was inspected for integrity, tip intact. Insertion site held with sterile gauze and hemostasis achieved within expected timeframe. Pressure bandage was applied to site. Pt was educated on dressing care and signs and symptoms to report to nurse. Review of Resident #3's progress note dated 4/3/2025 read, Plan . Abscess labia, Ceftriaxone 1 gram IM [intramuscular] daily for 3 days for a total of 10 days of therapy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/2025 at 8:30 AM, Staff A, Licensed Practical Nurse (LPN), Unit Manager, stated, [Resident #3's name] midline was inserted accidently and it had to be removed. [Staff B, LPN's name] was the nurse who put in the order for the intravenous medication. During an interview on 5/8/2025 at 8:44 AM, Staff B, LPN, stated, I don't recall much. I do think [the Advance Registered Nurse Practitioner #1's name] called and requested a midline to be inserted. During an interview on 5/8/2025 at 8:52 AM, the Director of Nursing stated, I spoke to [Staff A's name] and he said it [inserting a midline] was a mistake and a nurse caught the mistake and they removed the midline and corrected the order. I am not sure if the doctor was notified. During an interview on 5/8/2025 at 8:54 AM, the Advance Registered Nurse Practitioner #1 stated, [Resident #3's name] Ceftriaxone was never meant to be given intravenously. [Resident #3's name] was never meant to get a midline inserted. I never gave an order to insert a midline. This was a mistake from a nurse. I was there the following day and caught the mistake and the order was corrected. [Resident #3's name] received all her doses of the mediation intramuscularly. I was not aware the midline was actually put in. I would have then not had it [the midline] removed and just change the route of the medication to intravenous. The risk was minimal for the resident. There is always risk for infection, but very minimal if any. A midline is pretty benign. During an interview on 5/9/2025 at 8:39 AM, Staff C, LPN, stated, Originally what happened was I came on shift the nurse from the prior shift told me she [Resident #3] needed a PICC [Peripherally Inserted Central Catheter] line. When they [the organization that provides intravenious catheter insertions] came in they stated it would be best for a midline. I told my supervisor, and he said to change it [the physician's order] to a midline. I believe the midline was not used [for Resident #3]. When I came back the next time, she [Resident #3] no longer had a midline. The nurse who told me she [Resident #3] needed the PICC line was [Staff B's name]. Review of the facility policy and procedure titled Insertion of Peripheral Midline or Peripherally Inserted Central Catheters revised on 1/17/2019 read, General Guidelines . 4. Placing a midline or PICC requires a provider order and a written consent from resident or legal guardian.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 41334 Based on record review and interview, the facility failed to ensure residents' drug regimen were free from unnecessary antibiotic use based on adequate indications to reduce the risk of the development of antibiotic-resistant organisms for 1 of 3 residents reviewed for infection, Resident #7. Findings include: Review of Resident #7's physician order dated 5/4/2025 read, Ertapenem Sodium injection solution reconstituted 1 GM [gram], Inject 1 gram intramuscularly one time a day for UTI [Urinary Tract Infection] for 10 days. Review of Resident #7's physician order dated 5/4/2025 read, Urinalysis w [with]/reflex culture one time only related to quadriplegia, unspecified. Review of Resident #7's physician progress note dated 5/4/2025 read, Assessment/Plan: 1. Trach bleeding/Dark urine: Improved: No further episodes of bleeding from trach. Secretions are normal (pale yellow) in color, consistency. Eliquis was put on hold - but no improvement in color of urine. He has had history of UTI with brown-colored urine in March 2025. Ordered UA [urinalysis]/UC [urine culture] yesterday but do not see this. Will reorder. He was given water bolus to flush kidneys a bit but no improvement in urine color. With initial trach bleeding and concern for possible hematuria, Eliquis was put on hold. 2. Suspect UTI: As Eliquis does not seem to be cause of this (off it 40 hours without change), and with his history of UTI and he has suprapubic catheter - start Ertapenem 1 GM IV [intravenous] every 24 hours x 10 days. Primary team to be updated and to await UC results. Await labs as previously ordered. Review of Resident #7's nursing progress note dated 5/5/2025 read, Was unable to collect a urine sample. MD [Medical Doctor] has been notified. Awaiting new orders. Review of Resident #7's laboratory records showed no urinalysis or urine culture reports. Review of Resident #7's nursing progress notes from 5/5/2025 through 5/9/2025 showed no additional notes related to a urinalysis or urine culture. Review of resident #7's physician orders for 5/5/2025 through 5/9/2025 showed no additional orders for a urinalysis or urine cultures. During an interview on 5/9/2025 at 9:55 AM, the Infection Preventionist stated, This antibiotic [for Resident #7] should not have been continued. The weekend nurse practitioner started the resident on antibiotics empirically due to him having frequent UTIs. We did not get the culture and sensitivity, and we should have done this. He [Resident #7] is not having fevers. His white count was normal. He would not need this medication based on his clinical picture. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/2025 at 10:15 AM, Staff A, Licensed Practical Nurse (LPN), stated, I'm not sure why the urine was not recollected or attempted again. We should have notified the doctor or nurse practitioner and gotten that done. We should have followed up and gotten the order discontinued. During an interview on 5/9/2025 at 10:30 AM, the Director of Nursing (DON) stated, If a resident has burning on urination, sometimes the doctor will treat with wide spectrum antibiotics. We should collect a UA. We should have discontinued the antibiotic or gotten a UA. During an interview on 5/9/2025 at 10:41 AM, the Advanced Practice Registered Nurse stated, The antibiotics [for Resident #7] were prophylactic for possible symptoms [of a urinary tract infection]. We start antibiotics, get UA with culture and sensitivity. I am not sure why there wasn't a UA. I wanted the primary team to follow up on that and I guess they didn't. I would stop the antibiotic if the culture or U/A are negative or if the resident wasn't showing signs of a UTI.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 41334 Based on record review and interview, the facility failed to implement the antibiotic stewardship program by failing to monitor the use of antibiotics to reduce the risk of the development of antibiotic-resistant organisms for 1 of 3 residents reviewed for infection, Resident #7. Findings include: Review of Resident #7's admission record showed diagnoses that included, but not limited to, acute and chronic respiratory failure with hypoxia, personal history of traumatic brain injury, traumatic subarachnoid hemorrhage without loss of consciousness, tracheostomy status, gastrostomy status, neuromuscular dysfunction of bladder, post traumatic seizures, and quadriplegia. Review of Resident #7's physician order dated 5/4/2025 read, Urinalysis w [with]/reflex culture one time only related to quadriplegia, unspecified. Review of Resident #7's physician order dated 5/4/2025 read, Ertapenem Sodium injection solution reconstituted 1 GM [gram], Inject 1 gram intramuscularly one time a day for UTI [Urinary Tract Infection] for 10 days. Review of Resident #7's physician progress note dated 5/4/2025 read, Assessment/Plan: 1. Trach bleeding/Dark urine: Improved: No further episodes of bleeding from trach. Secretions are normal (pale yellow) in color, consistency. Eliquis was put on hold - but no improvement in color of urine. He has had history of UTI with brown-colored urine in March 2025. Ordered UA [urinalysis]/UC [urine culture] yesterday but do not see this. Will reorder. He was given water bolus to flush kidneys a bit but no improvement in urine color. With initial trach bleeding and concern for possible hematuria, Eliquis was put on hold. 2. Suspect UTI: As Eliquis does not seem to be cause of this (off it 40 hours without change), and with his history of UTI and he has suprapubic catheter - start Ertapenem 1 GM IV [intravenous] every 24 hours x 10 days. Primary team to be updated and to await UC results. Await labs as previously ordered. Review of Resident #7's nursing progress note dated 5/5/2025 read, Was unable to collect a urine sample. MD [Medical Doctor] has been notified. Awaiting new orders. Review of Resident #7's laboratory records showed no urinalysis or urine culture reports. Review of Resident #7's nursing progress notes from 5/5/2025 through 5/9/2025 showed no additional notes related to a urinalysis or urine culture. Review of resident #7's physician orders for 5/5/2025 through 5/9/2025 showed no additional orders for a urinalysis or urine cultures. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/2025 at 9:55 AM, the Infection Preventionist stated, This antibiotic [for Resident #7] should not have been continued. The weekend nurse practitioner started the resident on antibiotics empirically due to him having frequent UTIs. We did not get the culture and sensitivity, and we should have done this. This would not be appropriate, we need to follow our antibiotic stewardship for all antibiotics to prevent possible MDROs [multi drug resistant organisms]. He [Resident #7] is not having fevers. His white count was normal. He would not need this medication based on his clinical picture. During an interview on 5/9/2025 at 10:15 AM, Staff A, Licensed Practical Nurse (LPN), stated, I'm not sure why the urine was not recollected or attempted again. We should have notified the doctor or nurse practitioner and gotten that done. We should have followed up and gotten the order discontinued. During an interview on 5/9/2025 at 10:30 AM, the Director of Nursing (DON) stated, If a resident has burning on urination, sometimes the doctor will treat with wide spectrum antibiotics. We should collect a UA. We should follow our policies for antibiotic stewardship. We should have discontinued the antibiotic or gotten a UA. During an interview on 5/9/2025 at 10:41 AM, the Advanced Practice Registered Nurse stated, The antibiotics [for Resident #7] were prophylactic for possible symptoms [of a urinary tract infection]. We start antibiotics, get UA with culture and sensitivity. I am not sure why there wasn't a UA. I wanted the primary team to follow up on that and I guess they didn't. I would stop the antibiotic if the culture or U/A are negative or if the resident wasn't showing signs of a UTI. Review of the facility policy and procedure titled Antibiotic Stewardship read, Policy Statement: Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. Policy Interpretation and Implementation: 1. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents . 4. If an antibiotic is indicated, prescribers will provide complete antibiotic orders including the following elements: a. Drug name; b. Dose; c. Frequency of administration; d. Duration of treatment: 1) start and stop date; or 2) number of days of therapy e. route of administration; and f. indications of use . 11. When a culture and sensitivity (C&S) is ordered lab results and the current clinical condition will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified or discontinued.