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	05/23/2024

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523 Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for language and communication for 1 of 3 residents reviewed, Resident #155. Findings include: During an interview on 5/20/2024 at 10:31 AM, Resident #155 stated in Spanish, I only speak Spanish and at times I have a hard time communicating with staff. Review of Resident #155's Medicare 5-Day Minimum Data Set (MDS) dated [DATE] showed the assessment read, Section A: Identification information. A110. Language: Spanish. Review of Resident #155's care plan did not include language or communication as a focus. During an interview on 5/22/2024 at 12:22 PM, the MDS Coordinator stated, I don't see where he is care planned for communication. I will translate for him. Nurses who take care of him and communicate with him in Spanish. The social services also speaks Spanish. We spoke to therapy to get him a picture board. Review of the facility policy and procedures titled Plans of Care with the last approval date of 12/22/2023, showed the policy read, Policy: An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements . Procedure: Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment . Review, update and/or revise the comprehensive plan of are based on changing goals, preferences and needs of the resident and in response to current interventions after completion of each OBRA [Omnibus Budget Reconciliation Act] MDS [Minimum Data Set] assessment (except discharge assessments), and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 41334 Based on observation, interview, and record review, the facility failed to ensure medications were administered appropriately for 3 of 9 reviewed residents with enteral tube, Residents #91, #96, #151, and for 1 of 2 residents with central catheters, Resident #260. Findings include: 1. During an observation of medication administration on 5/22/2024 at 10:45 AM, Staff D, Registered Nurse (RN), prepared 5 medications for Resident #91. Staff D entered Resident #91's room and disconnected the enteral feeding from the pump and from the resident. Staff D did not verify gastrostomy tube placement and immediately administered 60 milliliters of water by pushing the piston of the feeding syringe and not letting water flow via gravity. Staff D administered all 5 medications one after the other without flushing the enteral feeding tube between medications. All 5 medications were administered by pushing down the piston of the syringe and not by gravity flow. Staff D flushed the enteral tube with 15 milliliters of water. During an interview on 5/22/2024 at 10:55 AM, Staff D, RN, stated, I should have checked for placement by checking for any residual in his stomach. I did not flush between each medication. Review of the facility policy and procedures titled Specific Medication Administration Procedures, Enteral Tube Medication Administration with the last approval date of 12/22/2023 read, Policy: The facility assures the safe and effective administration of enteral formulas and medications via enteral tubes. Selection of enteral formulas, routes and methods of administration, and the decision to administer medications via enteral tubes are based on nursing assessment of the resident's condition, in consultation with the physician, dietitian, and consultant pharmacist. Procedures . L. With clubs on, check for proper tube placement checking gastric residual volume (GRV). Never check placement with water . P. Administer each medication separately and flush the tubing between each medication: 1) Place 15 ml (or prescribed amount) of room temperature water in syringe and flush tubing using gravity flow. Clamp tubing after the syringe is empty, allowing water to remain in the tube. 2) Pour dissolved/diluted medication in syringe and unclamped tubing, allowing medication to flow by gravity. 3) Flush tube with 15 ml (or prescribed amount) of water between each medication. Pinch tubing below the syringe tip when each volume of liquid clears the syringe to avoid excessive air from entering the stomach. 2. During an observation of Intravenous (IV) medication administration via midline catheter on 5/21/2024 at 6:30 AM, Staff B, RN, assembled all supplies to administer Resident #260's IV antibiotic. Staff B cleaned the needleless connector of the right arm midline catheter for less than 2 seconds. Staff B did not visualize the insertion site of the midline catheter and attached the 10-milliliter normal saline syringe and without verifying midline placement, infused the normal saline. Staff B let go of the midline catheter line and it touched Resident #260's skin as she reached for the IV antibiotic. Staff B attached the IV antibiotic with cleaning the needleless connector and began the antibiotic infusion. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/2024 at 12:02 PM, the Director of Nursing (DON) stated, I can't find a specific central line flush policy and procedure. I expect staff to clean the connector, check for blood return, and to assess the site while they administer the medications. 46523 2. During an observation on 5/20/2024 at 10:04 AM, Resident #151 was sitting in a wheelchair in his room. There was a medication cup with two white circular pills on top of the bedside table. Resident #151 grabbed the two circular pills and self-administered them. During an interview on 5/20/2024 at 10:04 AM, Resident #151 stated, The two [Name of Medication] are for pain. As a matter of fact, I should drink them now. During an observation on 5/21/2204 at 12:29 PM, Staff N, Licensed Practical Nurse (LPN), was standing at Resident #96's doorway. Staff N was pouring medications into a medication cup. Staff N placed all medications into a clear sleeve and crushed all medications. Staff N entered the room with two medication cups with liquid medication and a cup with powder medication in her hand. Staff N administered medication enterally to Resident #96. During an interview on 5/23/2024 at 9:33 AM, Staff N, LPN, stated, I did crush all the medications together. I should have put each medication in an individual medication cup, crush separately and administer individually via [Resident #96's name] gastric tube. During an interview on 5/23/2024 at 9:36 AM, the DON stated, Staff should have crushed [Resident #96's name] medication individually and administering the medication via gastric tube individually, not all at once. [Resident #151's name] is not able to self-administer medication. Medication should not be left at bedside. Review of the facility policy and procedures titled General Guidelines for Administering Medication Via Enteral Tube with the last review date of 12/22/2023, showed the policy read, Policy: The facility assures the safe and effective administration of enteral formulas and medications via enteral tubes . Procedures . E . 2. Crushed medications are not mixed together. The powder from each medication is mixed with 15 ml [milliliters] of water before administration.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41334 Based on observation, interview, and record review, the facility failed to ensure that residents received wound care treatment in accordance with professional standards of practice for 4 of 4 residents reviewed for wound care, Residents #91, #73, #133 and #155. Findings include: 1. Review of Resident #91's admission record showed the resident was most recently admitted on [DATE] with diagnoses including gastrostomy status, colostomy status, acute and chronic respiratory failure with hypoxia, tracheostomy status, and stage 4 pressure ulcer of sacral region. Review of Resident #91's nursing progress notes dated 5/18/2024 at 7:56 PM read, Family performed wound care on resident by themselves. Family was educated on the importance of infection control and safety precautions. During an interview on 5/21/2024 at 4:10 PM, Resident #91's Representative stated, I changed his dressing because they didn't. I told the nurse that. The dressing was in need of getting done. During an observation on 5/22/2024 at 6:40 AM, Staff G, Certified Nursing Assistant (CNA), entered Resident #91's room and donned gloves without performing hand hygiene. Staff G did not don gown and assisted Resident #91 to left side, removed brief and placed a new brief on and repositioned the resident. The resident had a sacral dressing with a large amount of drainage on the foam dressing, which was dated 7/20/2024. During an interview on 5/22/2024 at 6:40 AM, Staff G, CNA, stated, The dressing is dated 7/20/2024. It should be done every day. I'll let the nurse know. Review of Resident #91's physician order dated 5/18/2024 read, Coccyx: cleanse with N/S [normal saline], pat dry, apply Medi-honey, collagen particles, cover with Calium alginate, top with bordered foam dressing every day shift for wound care related to pressure ulcer of sacral region, stage 4 . Start Date: 5/19/2024. Review of Resident #91's Treatment Administration Record for May 2024 showed no entries documented on 5/19/2024, 5/21/2024, and 5/22/2024 for Coccyx: cleanse with N/S [normal saline], pat dry, apply Medi-honey, collagen particles, cover with Calium alginate, top with bordered foam dressing every day shift for wound care related to pressure ulcer of sacral region, stage 4. Start Date: 5/19/2024. Review of Resident #91's Treatment Administration Record for May 2024 showed no entries documented on 5/1/2024, 5/2/2024, 5/3/2024, 5/7/2024, 5/8/2024, and 5/16/2024 for Cleanse coccyx with n/s saline, pat dry, apply medi-honey and collagen particles, cover with Calium alginate, top with bordered foam dressing every day shift related to pressure ulcer of sacral region, stage 4. Start Date: 4/20/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/22/2024 at 1:35 PM, Staff E, Licensed Practical Nurse (LPN), assembled all wound care supplies. Staff E repositioned Resident #91 and removed his brief to complete wound care. Resident #91's sacral wound had a dressing dated 7/20/2024 and there was a large amount of serosanguineous drainage on the dressing. During an interview on 5/22/2024 at 2:15 PM, Staff E, LPN, stated, The dressing is dated 7/20/2024 and should be changed daily. I don't know why it wasn't done. During an interview on 5/23/2024 at 6:15 AM, the Director of Nursing (DON) stated, All wound care dressings should be done and accurately documented in the residents record. 2. During an observation on 5/20/2024 at 10:19 AM, Resident #73 was in bed with left foot elevated on pillows. The resident's left heel dressing was dated 5/17/2024. During an interview on 5/20/2024 at 10:20 AM, Resident #73 stated, That has not been changed since a few days ago. They forget to change the dressing sometimes. They say they are too busy, or they will do it later and don't come back. During an observation on 5/22/2024 at 6:23 AM, Resident #73 was in bed, with left leg elevated on a pillow. Resident #73's left heel dressing was dated 5/20/2024. During an interview on 5/22/2024 at 7:05 AM, Staff I, LPN, stated, I see it needs to be changed. It is a daily dressing. It should have been changed. During an observation on 5/23/2024 at 7:26 AM, Resident #73 was in bed, with left leg elevated on a pillow. The resident's left heel dressing was dated 5/20/2024. During an interview on 5/23/2024 at 10:29 AM, Staff O, LPN confirmed that the date on the dressing was 5/20/2024 and stated, This is a daily dressing, and it should have been changed 2 days ago. The dressing was not changed for the last 2 days and should have been. Review of the facility policy and procedure titled Dressing Change with the last revision date of 12/6/2017 and the last approval date of 12/22/2023 read, Policy: A clean dressing will be applied by a nurse to a wound as ordered to promote healing. Sterile dressing will be used if specifically ordered. Procedure . Perform hand hygiene, apply gloves, remove and dispose of soiled dressing, remove gloves, perform hand hygiene, apply gloves, evaluate wound for type, color, amount of discharge, cleanse wound as ordered, dispose of gauze, remove gloves and perform hand hygiene, apply treatment as order [Sic.] and clean dressing, discard gloves and perform hand hygiene, document in the medical record. 46523 3. During an observation on 5/20/2024 at 9:46 AM, Resident #133's right thigh dressing was dated 5/16/2024. During an interview on 5/20/2024 at 9:46 AM, Resident #133 stated, Staff should come every day to change my dressing and they have not come since last Thursday. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/22/2024 at 12:30 PM, with Staff M, CNA, Resident #133's right thigh dressing was dated 5/20/2024. During an interview on 5/22/2024 at 12:30 PM, Resident #133 stated, They did not come yesterday to do my wound care. I have orders for daily wound care. Review of Resident #133's physician order dated 4/26/2204 showed the order read, Gentamicin Sulfate External Ointment 0.1% (Gentamicin Sulfate (Topical)) Apply to posterial [Sic.] thigh topically every day shift for wound care. Review of Resident #133's physician order dated 5/18/2024 showed the order read, Rt [Right] posterior thigh: Clean w N/S, pat dry w [with] gauze, apply Gentamicin 1% ointment, collagen powder, calcium alginate, top w border foam dressing daily every day shift for wound care. During an interview on 5/23/2024 at 7:10 AM, the DON stated, [Resident #133's name] has orders for dressings daily. Staff should be providing treatment following the physician orders. 4. During an observation on 5/20/2024 at 10:31 AM, Resident #155 was in bed. The resident had a surgical wound in his abdomen with a visibly soiled dressing dated 5/16/2024. Resident #155 had no wound vac [vacuum] connected to wound. During an interview on 5/20/2024 at 10:31 AM, Resident #155 stated that the staff removed the wound vac three days ago. During an observation on 5/22/2024 at 9:00 AM, Resident #155 was lying in bed, with the abdominal wound dressing dated 5/20/2024. During an observation on 5/22/2024 at 1:00 PM with Staff F, LPN, Unit Manager, and Assistant Director of Nursing (ADON), they confirmed that Resident #155's dressing was dated 5/20/2024. Review of Resident #155's physician order dated 4/28/2024 showed the order read, Abdomen: clean w N/S, pat dry, apply wound vac, cover with transparent film every night shift other day for wound care, use wet to moist kerflix packing, cover w ABD [abdomen] daily for vac failure. Review of Resident #155's physician order dated 5/18/2024 showed the order read, If wound vac needs to be turned off for any care, test/procedures, or for transport, remove the dressing in its entirety, cleanse wound with NS and use wet to moist Kerflix packing w ABD daily for vac failure. Review of Resident #155's wound assessment report dated 5/16/2024 showed the assessment read, Observations: Location: abdomen, Etiology: Surgical . Wound Status: Improving with delayed wound closure . Treatment: Dressing Change Frequency: 3 times per week. Clean Wound With: Cleanse with normal saline . Other Dressings: Transparent film, use wet to moist kerflix packing and cover with ABD daily for VAC failure. Review of Resident #155's progress note dated 5/20/2024, showed the progress note read, Writer wasn't able to place wound vac on resident. Wound Vac supplies not available. Writer placed PRN [as needed] wound care order for wound vac failure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/2024 at 7:14 AM, the DON stated, [Resident #155's name] order stated when he does not have a wound vac, dressing should follow the PRN order and do the dressing change daily.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 46523 Based on observation, interview, and record review, the facility failed to ensure residents received appropriate care and services for enteral nutrition for 2 of 4 residents reviewed for gastric feeding tubes, Residents #96 and #151. Findings include: 1. During an observation on 5/20/2024 at 9:30 AM, Resident #96's tube feeding formula bottle and water bag were empty. The feeding machine was beeping. There was an empty Jevity 1.5 formula bottle with no labeling. During an observation on 5/21/2024 at 12:25 PM, Resident #96 was receiving Jevity 1.5 via feeding tube at 50 milliliters per hour. During an observation on 5/22/2024 at 7:30 AM, Resident #96 was receiving Jevity 1.5 via feeding tube at 50 milliliters per hour. During an observation with Staff D, Registered Nurse (RN), on 5/22/2024 at 11:55 AM, Staff D confirmed Resident #96's feeding rate was 50 ml/hr [milliliter per hour] and the auto flush rate was running at 60 ml/hr. Review of Resident #96's physician order dated 5/17/2024 showed the order read, Enteral Feed Order one time a day Jevity 1.5 @ 55 ml/hr x 20 hrs on 2 pm off 10 am. Review of Resident #96's physician order dated 5/17/2024 showed the order read, Enteral Feed Order one time a day autoflush @ [at] 40 ml/hr x 20 hrs on 2 pm off 10 am. Review of Resident #96's care plan initiated on 2/19/2024 showed the care plan read, Focus: [Resident #96's name] is at risk for nutritional problem and malnutrition . Interventions . Tube feed per order. Flushes per order. Review of Resident #96's Weight and Vitals Summary showed the resident's weight was 106.7 pounds on 5/10/2024 and 105.4 pounds on 5/22/2024, which is a -1.22% weight loss. During an interview on 5/22/2024 at 4:00 PM, the Registered Dietician stated, Weight can go up and down some but there should not be a big change. A pound or two is not worrisome. Not being on the right feeding rate could affect his weight. The autoflushes would not affect him. It is just like drinking a little extra water. During an interview on 5/23/2024 at 7:15 AM, the Director of Nursing (DON) stated, The nurse should verify the orders and the milliliters that a feeding and flush should be running. 2. During an observation on 5/20/2024 at 10:04 AM, Resident #151 was sitting in wheelchair in room. Tube feeding dressing was dated 5/13/2024. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/2024 at 10:04 AM, Resident #151 stated, They have not changed my dressing for days. I do not know why I still have the feeding tube. It was placed during my hospital stay, but I do not need it anymore. All my food is by mouth and my medication is by mouth. Review of Resident #151's physician order dated 4/8/2024 read, Regular diet, Regular texture, regular/thin consistency, for diet. Review of Resident #151's physician order dated 4/15/2024 read, Change g tube [gastric tube] dressing daily in the afternoon for g tube dressing, dysphagia, essential hypertension, generalized anxiety, restlessness and agitation. Review of Resident #151 physician order dated 5/21/2024 read, Clean gtube area with n/s [normal saline] with T drain gauze to prevent any infection every night shift. During an interview on 5/23/2024 at 7:16 AM, the DON stated, [Resident #151's name] should have been evaluated earlier when he arrived back in April [2024] but I was not here at that time. Gastric tube dressing should be changed daily and go by physician orders. Review of the facility policy and procedures titled Enteral Feeding- Enteral Nutrition Pump with the last review date of 12/22/2023 read, Policy: Nurses administer enteral feeding when volume control is indicated and as ordered by physician. Procedure: Obtain physician's order . Follow pump manufacturer's guidelines. Set pump to physician orders.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41334 Based on observation, interview, and record review, the facility failed to ensure residents received appropriate respiratory care services for 2 of 5 residents reviewed for respiratory care, Residents #91 and Resident #96. Findings include: 1. Review of Resident #91's admission record showed the resident was admitted on [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia and tracheostomy status. Review of Resident #91's physician orders showed an order dated 3/28/2024 for administration of oxygen at 4 liters/minute via tracheostomy collar, with humidification every shift and as needed. Review of Resident #91's physician order dated 5/6/2024 read, Suction tracheostomy tube as needed to clear airway. Document results in PN [progress notes] as need for trach [tracheostomy] care. During an observation on 5/20/2024 at 10:30 AM, Resident #91 was in bed with a tracheostomy collar, receiving oxygen at 5 liters per minute. During an observation on 5/22/2024 at 6:02 AM, Resident #91 was in bed with a tracheostomy collar, receiving oxygen at 5 liters per minute. During an observation on 5/22/2024 at 10:45 AM, Resident #91 was in bed with a tracheostomy collar, receiving oxygen at 5 liters per minute. During an interview on 5/22/2024 at 10:50 AM, Staff D, Registered Nurse (RN), stated, His order is for 4 liters of oxygen. I don't know how that happened. During an observation on 5/22/2024 at 2:00 PM, Staff E, Licensed Practical Nurse (LPN), assembled supplies for tracheal suctioning for Resident #91. Staff E donned sterile gloves, and with the sterile gloves, turned on the suction machine with her right hand. Staff E placed the flexible suction tubing into the tracheostomy and the tubing was touching the side of the tracheostomy collar. Staff E cleaned the flexible suction catheter with normal saline. Staff E waited 30 seconds and had the flexible suction catheter curled into her right gloved hand. After 30 seconds, Staff E applied suction while inserting the flexible catheter tubing into the tracheostomy, eliciting a cough, and removing the flexible catheter removing secretions. Staff E did not assess or auscultate breath sounds prior to or after completion of suctioning. During an interview on 5/22/2024 at 2:15 PM, Staff E, LPN, stated, I didn't realize that I touched the suction machine or the edge of the trach collar. I should not have. I didn't think that I had applied the suction when going down his tube. I should have assessed his lung sounds. During an interview on 5/23/2024 at 6:20 AM, the Director of Nursing (DON) stated, I expect the nurses to follow our policies related to suctioning and oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedures titled Suctioning- Ventilator Dependent Residents with the last revision date of 8/24/2017, and the last approval date of 12/22/2023 read, Procedure . Perform hand hygiene . Set suction appropriately, Open the catheter packet and using sterile technique, place it near the resident's head, Put on gown and assess need for mask. Put on sterile gloves and grasp the catheter, Assess breath sounds . Hold the catheter so that its natural curve is aligned with the endotracheal or tracheostomy tube. Without applying suction, quickly and gently insert the catheter through the tube until the resident coughs or a slight obstruction is felt. Never force a catheter further if an obstruction is met. Withdraw the catheter 0.5 cm [centimeters] and apply suction while rotating the catheter between the thumb and forefinger. Each pass of the catheter should be no longer than 5-10 seconds and for no longer than 5 minutes in total. Repeat Step 12 . Assess sputum: color, consistency, odor, and amount. Send specimen if indicated. Assess breath sounds. 46523 2. During an observation on 5/20/2024 at 9:31 AM, Resident #96 was lying in bed with a speaking cap on tracheostomy site. A nasal cannula was hanging on the side of the bedrail and an oxygen concentrator was running at 3 liters per minute. During an observation on 5/21/2024 at 8:00 AM, Resident #96 was lying in bed with a speaking cap on the tracheotomy site, with oxygen being administered at 3 liters per minute via nasal cannula. Review of Resident #96's physician orders showed an order dated 4/22/2024 for administration of oxygen at 4 liters/minute via tracheostomy collar, with humidification every shift. Review of Resident #96's care plan initiated on 4/5/2024 showed the care plan read, Focus: [Resident #96's name] exhibits or is at risk for respiratory complications related to dx [diagnosis] of: pneumonia, interstitial pulmonary disease, respiratory failure with hypercapnia, tracheostomy status, personal history of COVID-19, and hx [history] of pneumonitis due to aspiration . Interventions: Administer oxygen as ordered (Refer to MAR [Medication Treatment Record] for current order. During an interview on 5/23/2024 at 7:15 AM, the DON stated, Staff should be checking the order and check the rate on the oxygen machine making sure that it matches and adjust if it has been changed. Review of the facility policy and procedures titled Oxygen Therapy with the last review of 12/22/2023, showed the policy read, Procedure: Review physician orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Aspire at Arbor Springs		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 SE 24th Rd Ocala, FL 34471	

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41334 Based on observation, record review and interview, the facility failed to ensure medical records were accurate for 4 of 4 residents reviewed for wound care, Residents #91, #73, #133 and #155, for 1 of 2 residents with central catheter, Resident #260, and for 1 of 4 residents with feeding tube, Resident #151. Findings include: 1. Review of Resident #91's admission record showed the resident was most recently admitted on [DATE] with diagnoses including gastrostomy status, colostomy status, acute and chronic respiratory failure with hypoxia, tracheostomy status, and stage 4 pressure ulcer of sacral region. Review of Resident #91's Treatment Administration Record (TAR) for May 2024 showed no entries documented on 5/1/2024, 5/2/2024, 5/3/2024, 5/7/2024, 5/8/2024, and 5/16/2024 for Cleanse coccyx with n/s [normal saline] saline, pat dry, apply medi-honey and collagen particles, cover with Calium alginate, top with bordered foam dressing every day shift related to pressure ulcer of sacral region, stage 4. Start Date: 04/20/2024. D/C [Discontinue] Date: 05/16/2024. Review of Resident #91's TAR for May 2024 showed no entries documented on 5/19/2024, 5/21/2024, and 5/22/2024 for Coccyx: cleanse with N/S, pat dry, apply Medi-honey, collagen particles, cover with Calium alginate, top with bordered foam dressing every day shift for wound care related to pressure ulcer of sacral region, stage 4. Start Date: 05/19/2024. Review of Resident #91's TAR for May 2024 showed no entries documented on 5/10/2024, 5/12/2024, 5/13/2024, 5/14/2024, 5/15/2024 and 5/17/2024 at 6:00 AM for Suction tracheostomy tube as needed to clear airway. Document results in PN [progress notes] two times a day for Trach [tracheostomy] care. Start Date: 05/06/2024. Review of Resident #91's TAR for May 2024 showed no entries documented on 5/7/2024, 5/20/2024, 5/21/2024, and 5/22/2024 at day shift for Tracheostomy site dressing change every shift for Trach care. Start Date: 05/06/2024. 2. Review of Resident #260's admission record showed the resident was most recently admitted on [DATE] with diagnoses including oral pharyngeal phase dysphagia and gastrostomy status. Review of Resident #260's TAR for May 2024 showed no entries documented on 5/8/2024, 5/20/2024, 5/21/2024, and 5/22/2024 on the day shift and on 5/13/2024 on the night shift for Sacrum: Cleanse w [with] N/s [normal saline], pat dry, apply barrier cream every shift for wound care. Start Date: 05/07/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #260's TAR for May 2024 showed no entries documented on 5/1/2024, 5/3/2024, 5/7/2024, 5/8/2024, 5/20/2024, 5/21/2024, and 5/22/2024 on the day shift and on 5/13/2024 on the night shift for Enteral Feed Order every shift enteral tube care: Inspect surrounding skin of stoma for redness, tenderness, swelling, skin irritation, purulent drainage or signs of infection. Observe for gastric ulceration. Start Date: 02/02/2024. 3. Review of Resident #73's admission record showed the resident was most recently admitted on [DATE] with diagnoses including unspecified displaced fracture of sixth cervical vertebra subsequent encounter for fracture with routine healing, wedge compression fracture of T11 through T12 vertebrae, subsequent encounter for fracture with routine healing, and diabetes mellitus due to underlying condition without complications. Review of Resident #73's TAR for May 2024 showed no entries documented on 5/11/2024, 5/12/2024, and 5/18/2024 for Lt [Left] heel: clean w N/s, pat dry, apply Medi Honey, silver alginate, abd [abdomen] pad and rolled gauze every day shift for Wound Care. Start Date: 05/18/2024. D/C Date: 05/18/2024. Review of Resident #73's TAR for May 2024 showed no entries documented on 5/21/2024, and 5/22/2024 for Lt heel: clean w N/s, pat dry, apply Medi Honey, silver alginate, abd [abdomen] pad and rolled gauze every day shift for Wound Care. Start Date: 05/19/2024. During an interview on 5/23/2024 at 10:29 AM, Staff O, Licensed Practical Nurse (LPN), stated, All wound care should be documented when we do it. During an interview on 5/23/2024 at 10:45 AM, the Director of Nursing (DON) stated, We don't have a specific policy on documentation. Nurses should follow the accepted standard and document all care they give. Review of the facility policy and procedure titled Dressing Change with the last revision date of 12/6/2017 and the last approval date of 12/22/2023 read, Policy: A clean dressing will be applied by a nurse to a wound as ordered to promote healing. Sterile dressing will be used if specifically ordered. Procedure . Perform hand hygiene, apply gloves, remove and dispose of soiled dressing, remove gloves, perform hand hygiene, apply gloves, evaluate wound for type, color, amount of discharge, cleanse wound as ordered, dispose of gauze, remove gloves and perform hand hygiene, apply treatment as order [Sic.] and clean dressing, discard gloves and perform hand hygiene, document in the medical record. 46523 4. During an observation on 5/20/2024 at 9:46 AM, Resident #133's right thigh dressing was dated 5/16/2024. Review of Resident #133's TAR for May 2024 showed staff initials for administration of care on 5/17/2024 for Rt [Right] posterior thigh: Clean w N/S, pat dry w gauze, apply Gentamicin 1% ointment, collagen powder, calcium alginate, top w bordered foam dressing daily, every night shift for wound care. Start Date: 05/10/2024. D/C Date: 05/19/2024 During an observation on 5/22/2024 at 12:30 PM with Staff M, Certified Nursing Assistant (CNA), Resident #133's right thigh dressing was dated 5/20/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER: Aspire at Arbor Springs		STREET ADDRESS, CITY, STATE, ZIP CODE: 1501 SE 24th Rd, Ocala, FL 34471	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #133's TAR for May 2024 showed staff initials for administration of care on 5/19/2024 for Rt posterior thigh: Clean w N/S, pat dry w gauze, apply Gentamicin 1% ointment, collagen powder, calcium alginate, top w bordered foam dressing daily, every night shift for wound care. Start Date: 05/19/2024. During an interview on 5/23/2024 at 7:10 AM, the DON stated, [Resident #133's name] has orders for dressings daily. Staff should be providing treatment following the physician orders. 5. During an observation on 5/20/2024 at 10:04 AM, Resident #151's tube feeding dressing was dated 5/13/2024. During an interview on 5/20/2024 at 10:04 AM, Resident #151 stated, They have not changed my dressing for days. I do not know why I still have the feeding tube it was placed during my hospital stay but I do not need it anymore. All my food is by mouth and my medication is by mouth. Review of Resident #151's TAR for May 2024 showed staff initials for administration of care on 5/14/2024, 5/15/2024, 5/16/2024, 5/17/2024, 5/18/2024, and 5/19/2024 for Change G tube dressing daily in the afternoon for G tube dressing. Start Date: 04/15/2024. D/C Date: 05/21/2024. During an interview on 5/23/2024 at 7:19 AM, the DON stated staff were expected to accurately document the services provided. 6. During an observation on 5/20/2024 at 10:31 AM, Resident #155 was in bed. The resident had a surgical wound in his abdomen with a visibly soiled dressing dated 5/16/2024. Resident #155 had no wound vac [vacuum] connected to wound. During an interview on 5/20/2024 at 10:31 AM, Resident #155 stated that the staff removed the wound vac three days ago. During an observation on 5/22/2024 at 9:00 AM, Resident #155 was lying in bed, with the abdominal wound dressing dated 5/20/2024. During an observation on 5/22/2024 at 1:00 PM with Staff F, LPN, Unit Manager, and Assistant Director of Nursing (ADON), they confirmed that Resident #155's dressing was dated 5/20/2024. Review of Resident #155's TAR for May 2024 showed no entries documented on 5/4/2024, 5/10/2024, 5/16/2024, and 5/18/2024 for Abdomen: clean w N/S, pat dry, apply wound vac, cover with transparent film every night shift other day for wound care, use wet to moist kerflix packing, cover w ABD daily for vac failure. Start Date: 04/28/2024. During an interview on 5/23/2204 at 7:16 AM, the DON stated, Nursing should be documenting accurately and as needed in the resident treatment record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41334 Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene during medication administration, failed to ensure enhanced barrier precautions were followed and failed to ensure staff performed hand hygiene and followed infection control standards during wound care to prevent possible spread of infection and communicable diseases. Findings include: 1. During an observation on 5/21/2024 at 5:00 AM, Staff A, Registered Nurse (RN), unlocked the medication cart and obtained a blood glucose monitoring machine, blood glucose strips and alcohol wipe without performing hand hygiene. Staff A entered Resident #140's room, donned gloves without performing hand hygiene and obtained the blood glucose sample for testing. Staff A doffed gloves and exited the room without performing hand hygiene and returned to the medication cart. During an observation on 5/21/2024 at 5:05 AM, Staff A, RN, unlocked the medication cart and prepared Resident #460's medications without performing hand hygiene. Staff A entered Resident #460's room and administered the medications and exited Resident #460's room without performing hand hygiene and returned to the medication cart. During an observation on 5/21/2024 at 5:08 AM, Staff A, RN, unlocked the medication cart and prepared Resident #128's medications without performing hand hygiene. Staff A entered Resident #128's room without performing hand hygiene. Resident #128 asked for assistance with changing his colostomy bag. Staff A set medication cup on Resident #128's overbed table, donned gloves without performing hand hygiene, removed the full colostomy bag, and placed a new colostomy bag on Resident #128. Staff A then removed 2 full urinals from the overbed table, emptied them, removed a trash bag from the trach receptacle, exited Resident #128's room, leaving the medications at Resident #128's bedside unattended to dispose of the trash bag. Staff A returned to the medication cart and doffed gloves without performing hand hygiene and began preparing medication for another resident. During an observation on 5/21/2024 at 5:16 AM, Staff A, RN, unlocked the medication cart and obtained a blood glucose monitoring machine, blood glucose strips and alcohol wipe without performing hand hygiene. Staff A entered Resident #211's room and donned gloves without performing hand hygiene and obtained the blood glucose sample for testing. Staff A doffed gloves and exited the room without performing hand hygiene and returned to the medication cart. During an interview on 5/21/2024 at 5:19 AM, Staff A, RN, stated, I should have washed my hands before and after I get medication or do an accucheck [blood glucose monitoring sample]. I don't know why I didn't. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 5/21/2024 at 5:22 AM, Staff B, RN, unlocked the medication cart and prepared Resident #210's medication without performing hand hygiene. Staff B entered Resident #210's room and placed the medication cup in Resident #210's hand without performing hand hygiene. Resident #210 dropped the medication on the floor and Resident #210 picked up the medication and handed it to Staff B. Staff B took the medication into her ungloved hand and exited the room. Staff B wasted the medication. Staff B unlocked the medication cart and prepared the medication again without performing hand hygiene. Staff B entered Resident #210's room without performing hand hygiene and administered the medication and exited the room without performing hand hygiene and returned to the medication cart. During an observation on 5/21/2024 at 5:28 AM, Staff B, RN, unlocked the medication cart and obtained a blood glucose monitoring machine, blood glucose strips and alcohol wipe without performing hand hygiene. Staff B entered Resident #153's room, donned gloves, and obtained the blood glucose sample for testing without performing hand hygiene. Staff B doffed gloves and exited the room without performing hand hygiene and returned to the medication cart and began preparing medications for another resident. During an observation on 5/21/2024 at 6:30 AM, Staff B, RN, assembled all supplies and the medication for an IV (intravenous) medication administration without performing hand hygiene. Staff B entered Resident #260's room and donned gloves without performing hand hygiene. Staff B cleansed the needleless connector with alcohol for less than 2 seconds, flushed the IV midline catheter with normal saline flush and the needleless connector was touching Resident #260's skin. Staff B prepared the IV antibiotic and connected the medication to the needleless connector without cleaning the connector again. Staff B doffed gloves and exited the room without performing hand hygiene returning to the medication cart. During an interview on 5/21/2024 at 6:45 AM, Staff B, RN, stated, I should have washed my hands or used hand sanitizer. I should have cleaned the connector for longer. I didn't know that it touched his skin again after I cleaned it the first time. During an observation on 5/22/2024 at 8:06 AM, Staff C, Licensed Practical Nurse (LPN), unlocked the medication cart and prepared Resident #79's medications without performing hand hygiene. Staff C entered Resident #79's room and administered the medications without performing hand hygiene. Staff C exited the room and returned to the medication cart without performing hand hygiene. During an observation on 5/22/2024 at 8:10 AM, Staff C, LPN, unlocked the medication cart and prepared Resident #92's medication without performing hand hygiene. Staff C entered Resident #92's room, administered the medication, and exited the room without performing hand hygiene and returned to the medication cart. During an observation on 5/22/2024 at 8:15 AM, Staff C, LPN, unlocked the medication and prepared Resident #82's medication without performing hand hygiene. Staff C entered Resident #92's room and administered the medication without performing hand hygiene. Staff C exited the room and returned to the medication cart and began preparing another residents medication without performing hand hygiene. During an interview on 5/22/2024 at 8:22 AM, Staff C, LPN, stated, I really should have used hand sanitizer or washed my hands. I didn't realize I didn't. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 5/22/2024 at 10:45 AM, Staff D, RN, went to the medication cart and prepared Resident #91's medication without performing hand hygiene. Staff D entered Resident #91's room, donned gloves, and administered the medications without performing hand hygiene. Staff D doffed gloves, exited the room, returned to the medication cart, and began preparing another residents medication without performing hand hygiene. During an interview on 5/22/2024 at 11:05 AM, Staff D, RN, stated, I should have washed my hands before I gave those and after I took off my gloves. During an interview on 5/22/2024 at 11:15 AM, the Director of Nursing (DON) stated, I expect the staff to follow our infection control policies when giving medication. Review of the facility policy and procedure titled Hand Hygiene with the last revision date of 2/5/2021, and the last approval date of 12/22/2023 reads, Overview: The CDC [Centers for Disease Control and Prevention] defines hand hygiene as cleaning your hands by either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel). Purpose: To reduce the spread of germs in the healthcare setting. Purpose: To reduce the spread of germs in the healthcare setting. Process: Hand hygiene should be performed . Before initiating a clean procedure, Before and after patient care, After contact with blood, body fluids, or excretions, mucous membranes, non-intact skin or wound dressing, After contact with inanimate objects (including medical equipment) in the immediate patient vicinity . After glove removal. Review of the facility policy and procedures titled Medication Administration- General Guidelines with the last approval date of 12/23/2023 read, Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so . Procedures: A. Preparation . 2. Hand washing and hand sanitization: The person administering medications adheres to good hand hygiene, which includes washing hands thoroughly: before beginning a medication pass, prior to handling any medication, after coming in direct contact with a resident, and before and after administration of medications via enteral tubes. B. Hand sanitization is done with an approved sanitizer. Between hand washings, when returning to the medication cart or preparation area (assuming hands have not touched a resident or potentially contaminated surface.) At regular intervals during the medication pass such as after each room, again assuming hand washing is not indicated. 2. During an observation on 5/21/2024 at 6:25 AM, Resident #260 was resting in bed. There was no signage for enhanced barrier precautions and no supplies of PPE in or near Resident #260's room. Review of Resident #260's admission record showed the resident was most recently admitted on [DATE] with diagnoses including oral pharyngeal phase dysphagia and gastrostomy status. Review of Resident #260's physician order dated 5/14/2024 showed the order read, Enhanced barrier precautions due to indwelling medical device GTUBE [gastrostomy tube]. Review of Resident #260's care plan with an implementation date of 2/12/2024 read, Focus: The resident requires enhanced barrier precautions related to use of indwelling medical device G-tube and midline for IV ABT [Intravenous Antibiotic Therapy] and is at risk for a CDC MDRO infection . Interventions . Signage at designated area to alert staff and visitor of enhanced barrier precautions . Staff to wear enhanced barrier precaution PPE when providing high contact direct care activities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 5/21/2024 at 6:30 AM, Staff B, RN, entered Resident #260's room without performing hand hygiene, donned gloves without performing hand hygiene and did not don a gown. Staff B administered the IV medications and exited the room. During an interview on 5/21/2024 at 6:30 AM, Staff B, RN, stated, I should have used a gown and washed my hands before putting on gloves. There is no sign on the door. There are no gowns in his room and none outside his door. 3. During an observation on 5/20/2024 at 10:30 AM, Resident #91 was resting in bed with a tube feeding infusing, and with a tracheostomy. There was no signage for enhanced barrier precautions and no supplies of PPE in or near Resident #91's room. Review of Resident #91's admission record showed the resident was admitted on [DATE] with diagnoses including gastrostomy status, colostomy status, acute and chronic respiratory failure with hypoxia, tracheostomy status, and Stage 4 pressure ulcer of sacral region. Review of Resident #91's physician order dated 5/12/2024 showed the order read, Enhanced barrier precautions due to indwelling device trach [tracheostomy] and enteral feeding device. Review of Resident #91's care plan with an implementation date of 5/20/2024 read, Focus: Resident requires enhanced barrier precautions related to coccyx wound requiring a dressing/covering and is a high risk for a CDC MDRO infection . Interventions . Signage at designated area to alert staff and visitor of enhanced barrier precautions . Staff to wear enhanced barrier precaution PPE when providing high contact direct care activities. During an observation on 5/22/2024 at 6:40 AM, there was no enhanced barrier precautions signage and no supplies of PPE in or near Resident #91's room. Staff G, Certified Nursing Assistant (CNA), entered Resident #91's room and donned gloves without performing hand hygiene. Staff G did not don gown and assisted Resident #91 to left side, removed brief, placed a new brief on and repositioned the resident. Staff G doffed gloves and exited the room without performing hand hygiene. During an interview on 5/22/2024 at 6:55 AM, Staff G, CNA, stated, I don't think I need to wear a gown when I help [Resident #91's name]. He is not on isolation at all. During an observation on 5/22/2024 at 10:45 AM, there was no enhanced barrier precautions signage and no supplies of PPE in or near Resident #91's room. Staff D, RN, entered Resident #91's room and donned gloves without performing hand hygiene. Staff D did not don gown and administered the medications to Resident #91 through a gastrostomy tube. Staff D doffed her gloves without performing hand hygiene and exited the room. During an interview on 5/22/2024 at 11:05 AM, Staff D, RN, stated, I should have washed my hands before I gave those and after I took off my gloves. He is not on isolation, so I would not need to gown up to give him his medications. During an observation on 5/22/2024 at 1:35 PM, there was no enhanced barrier precautions signage and no PPE in or near Resident #91's room. Staff E, LPN, donned gloves, but did not don gown and performed wound care. Staff F, LPN, was assisting with wound care and repositioning of Resident #91. Staff F did not don a gown during the wound care procedure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 5/22/2024 at 2:00 PM, Staff E, LPN, assembled supplies for Resident #91 for tracheostomy care and suctioning. Staff E donned gloves without performing hand hygiene and without donning a gown. Staff E suctioned Resident #91 and performed tracheostomy care. Staff F, LPN, who was assisting during the procedure did not don a gown. During an interview on 5/22/2024 at 2:15 PM, Staff E, LPN, stated, I know he should be on enhanced barrier precautions. There is no signage and there are no gowns available. During an interview on 5/22/2024 at 2:17 PM, Staff F, LPN, stated, I know he is supposed to be on barrier precautions, but we have a PIP [Performance Improvement Plan) for that. That does not mean we shouldn't follow the doctor's orders or make sure that we have the signs and gowns. During an interview on 5/23/2024 at 6:15 AM, the DON stated, We know there is a concern with enhanced barrier precautions, but we have not been able to start a PIP. We have done some education and training and we have made sure that all residents with lines or tubes have the orders in place for enhanced barrier precautions. I expect all staff will follow these policies and wear the PPE and place the signage at the doorways. 4. Review of Resident #91's admission record showed the resident was most recently admitted on [DATE] with diagnoses including gastrostomy status, colostomy status, acute and chronic respiratory failure with hypoxia, tracheostomy status, and stage 4 pressure ulcer of sacral region. Review of Resident #91's physician order dated 5/18/2024 read, Coccyx: cleanse with N/S [normal saline], pat dry, apply Medi-honey, collagen particles, cover with Calium alginate, top with bordered foam dressing every day shift for wound care related to pressure ulcer of sacral region, stage 4 . Start Date: 5/19/2024. During an observation on 5/22/2024 at 1:35 PM, Staff E, LPN, assembled all supplies for wound care on a foil barrier and placed them on Resident #91's overbed table. Staff E did not clean the overbed table. The overbed table had dried tannish material in multiple areas. Staff E opened a package of 4x4 gauze and 3/4 of the gauze was on the table and not on the foil barrier. Staff E moistened the gauze with normal saline. Staff E donned gloves without performing hand hygiene, removed Resident #91's sacral dressing that was dated 5/20/2024 and had a large amount of serosanguinous drainage on the old foam dressing. Staff E cleaned the wound with the normal saline moistened gauze and the collagen particles within the wound bed, applied medihoney to the wound bed, applied the calcium alginate and covered the wound with a bordered foam dressing. Staff E doffed her gloves and exited the room to obtain suction supplies for Resident #91 without performing hand hygiene. During an observation on 5/22/2024 at 2:00 PM, Staff E, LPN, assembled all supplies for tracheostomy suctioning for Resident #91, placed the supplies on the overbed table, and donned sterile gloves from the suction kit without performing hand hygiene. Staff E turned on the suction machine with right gloved hand. Staff E suctioned the resident, placing the flexible suction catheter into the tracheostomy until she elicited a cough and applied suction and quickly removed the flexible suction catheter. Staff E cleaned the flexible suction catheter with normal saline. The tip of the flexible suction tubing was in touch with the tracheostomy mask collar prior to the first pass to suction the resident. While waiting 30 seconds staff had the flexible suction catheter curled into her right gloved hand. Staff suctioned again applying suction while going into the tracheostomy, eliciting a cough, and removing the flexible catheter removing secretions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Aspire at Arbor Springs		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 SE 24th Rd Ocala, FL 34471	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/22/2024 at 2:15 PM, Staff E, LPN, stated, I didn't realize that I touched the suction machine or the edge of the trach collar. I should not have. During an interview on 5/22/2024 at 6:18 AM, the DON stated, All staff should observe the policies and procedures for wound care and trach care. 46523 5. During an observation on 5/20/2024 at 12:01 PM, the Staff Development Nurse entered Resident #96's room. Staff Development Nurse disconnected the resident's tube feeding. The Staff Development Nuese was standing at bedside holding flush syringe. Staff Development Nurse had gloves on but did not wear gown. During an observation on 5/21/2024 at 12:29 PM, Staff N, LPN, was at Resident #96's doorway, pouring medications in a medication cup. Staff N put all the medications into a clear sleeve and crushed all medications together. Staff N poured the medication powder into a medication cup. Staff N entered Resident #96's room with two medication cups with liquid medication and a cup with white powder. Staff N administered the medications via gastric tube. Staff N did not wear a gown. During an observation on 5/22/2024 at 10:31 AM, Staff L, CNA, and Staff M, CNA, entered Resident #96's room without gowning. Staff M exited the room with soiled linens in a closed clear bag. Resident #96's room door had an enhanced barrier precaution sign posted on the door. There was no personal protective equipment outside of the room. During an interview on 5/22/2024 at 11:49 AM, Staff L, CNA, stated, When I entered [Resident #96's name] room, I put on gloves and no gown. I was assisting Staff M, CNA, to provide care for [Resident #96's name]. I did get education on gowning when entering a room where a resident has an injury. [Staff M's name] did not do anything with the urinary catheter other than drain the urine in the bag. Review of Resident #96's physician order dated 5/12/2024 showed the order read, Enhanced barrier precautions due to indwelling device Gtube [gastrostomy], tracheostomy, supra pubic catheter and wounds. During an interview on 5/22/2024 at 11:52 AM, Staff M, CNA, stated, I did not wear a gown while I was providing care for [Resident #96's name]. I did empty the urinary catheter and readjusted the bag back on the rail since it was on the floor. During an interview on 5/23/2024 at 9:33 AM, Staff N, LPN, stated, I did not gown because normally there will be a sign on the door and personal protective equipment outside of the room and [Resident #96's name] did not have any of those in place. 6. During an observation on 5/22/2024 at 12:31 PM, Staff M, CNA, provided peri care to Resident #133 without donning a gown. Review of Resident #133's physician order dated 5/16/2024 showed the order read, Enhanced barrier precautions due to wound. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/23/2204 at 7:15 AM, the DON stated, Staff should don gown and gloves when providing care to any of the splash zone. If the residents have a MDRO [Multidrug Resistant Organisms], indwelling device and wound. 7. During an observation on 5/22/2024 at 10:58 AM, Staff F, LPN, Unit Manager, and the Assistant Director of Nursing provided wound care for Resident #96. Staff F washed her hands and donned gloves. Staff F removed the old dressing from the left heel, removed her gloves and washed her hands. Staff F donned new gloves and applied normal saline to a 4x4 gauze and cleaned wound without performing hand hygiene or changing gloves. Staff F then applied the treatment to the wound and applied new dressing. Staff F removed her gloves and washed her hands. Staff F donned new gloves. Resident #96's left lateral foot did not have a dressing in place. Staff F cleaned the area and applied treatment without performing hand hygiene. Staff F placed a new dressing to the wound. Staff F performed hand hygiene and donned gloves. Staff F removed two dressings from the right ischium and buttocks area. Staff F performed hand hygiene and cleansed the right ischium wound without performing hand hygiene. Staff F then applied the treatment to the wound and covered it with a new dressing. Staff F removed gloves and washed her hands. Staff F donned gloves and cleansed Resident #96's right buttock. Staff F, without hand hygiene, applied the treatment and new dressing. Then, Staff F performed hand hygiene and donned gloves. Staff F removed the old dressing and performed hand hygiene and donned gloves. Staff F cleansed the coccyx. The gauze was visibly soiled with serosanguinous drainage and inner section of wound came in slight contact with Resident #96's briefs. Staff F, without performing hand hygiene, applied the treatment to the wound area and applied a new dressing. Staff F washed her hands and donned new pair of gloves. Staff F removed the old dressing and performed hand hygiene. Staff F donned a new pair of gloves and cleaned wounds located on Resident #96's spine. Then, Staff F, without performing hand hygiene, applied treatment to the wound and applied a new dressing. Staff F performed hand hygiene, donned a new pair of gloves and removed the dressing on the left ischium. Staff F performed hand hygiene and donned new gloves. Staff F cleaned the wound area and, without performing hand hygiene, applied treatment and new dressing. During an interview on 5/22/2024 at 11:48 AM, Staff F, LPN, Unit Manager, stated, I did not sanitize my hands after cleaning the wounds. I missed that step. During an interview on 5/23/2024 at 7:15 AM, the DON stated, Nursing staff should be doing wound care according to policy. I would consider that nurses' hands would be contaminated after cleaning a wound. Review of the facility policy and procedure titled Dressing Change with the last revision date of 12/6/2017 and the last approval date of 12/22/2023 read, Policy: A clean dressing will be applied by a nurse to a wound as ordered to promote healing. Sterile dressing will be used if specifically ordered. Procedure . Perform hand hygiene, apply gloves, remove and dispose of soiled dressing, remove gloves, perform hand hygiene, apply gloves, evaluate wound for type, color, amount of discharge, cleanse wound as ordered, dispose of gauze, remove gloves and perform hand hygiene, apply treatment as order [Sic.] and clean dressing, discard gloves and perform hand hygiene. 48865 8. During an observation on 5/22/2024 at 11:18 AM, there was no enhanced barrier precaution signage in or around Resident #127's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 5/22/2024 at 11:18 AM, Staff J, LPN, was administering medications to Resident #127 through a gastrostomy tube. Staff J did not wear a gown. During an interview on 5/22/2024 at 11:18 AM, Staff J, LPN, stated, I would not normally gown up for gastrostomy tube medication administration. During an observation on 5/22/2024 at 11:22 AM, there was no enhanced barrier precaution signage in or near Resident #127's door. During an interview on 5/23/2024 at 7:38 AM, the DON stated, Staff would normally gown up for enhanced barrier precautions for gastrostomy tube care. During an observation on 5/23/2024 at 8:24 AM, there was no signage or equipment around or in Resident #127's room. Staff K, LPN, flushed the resident's gastrostomy tube with water, wearing gloves. Staff K did not wear any other personal protective equipment. Review of Resident #127's admission record showed the resident was admitted on [DATE] with the diagnoses including oral phase dysphagia and gastrostomy status. Review of Resident #127's physician order dated 5/12/2024 showed the order read, Enhanced Barrier Precautions due to indwelling device enteral feed device. Review of Resident #127's care plan dated 5/12/2024 showed the care plan read, Focus: The resident requires enhanced barrier precautions related to use of indwelling medical device (enteral feeding device) and is at risk for a CDC [Centers for Disease Control and Prevention] MDRO [Multidrug Resistant Organism) infection. Interventions . Signage at designated area to alert staff and visitor of enhanced barrier precautions . Staff to wear enhanced barrier precaution PPE [Personal Protective Equipment) when providing high contact direct care activities. Review of the facility policy and procedures titled Enhanced Barrier Precautions with the last approval date of 12/22/2023 read, Policy Statement: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation: 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDRO's) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room) . 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include . d. providing hygiene . f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. Wound care (any skin opening requiring a dressing) . 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. 6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the medical device that places them at increased risk . 10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. 11. PPE is available outside of the resident room.