

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Aspire at North Fort Myers		STREET ADDRESS, CITY, STATE, ZIP CODE 991 Pondella Rd N FT Myers, FL 33903	

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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44824</p> <p>Based on resident and staff interviews and record reviews the facility failed to follow Physician orders to ensure the health and safety of one resident, Resident #1, of 4 residents reviewed for significant medication errors.</p> <p>The findings included:</p> <p>Administering Medications Policy dated 2001 and Revised April 2019 states, Medications are administered in a safe and timely manner, and as prescribed.</p> <p>If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the Medication Administration record space provided for that drug and dose.</p> <p>As required or indicated for a medication, the individual administering the medication records in the resident's medical record: The date and time the medications was administered; the dosage; the route of administration; the injection site; Any complaints or symptoms for which the drug was administered; Any results achieved and when those results were observed; and the signature and title of the person administering the drug.</p> <p>Medical record review for Resident #1 show he was admitted to the facility on [DATE] for post Cerebrovascular Accident (CVA) causing left upper and lower paralysis. He also had a history of diabetes.</p> <p>His cognition was evaluated using the BIMS (Brief Interview for Mental Status) and had a score of 15 out of 15 which indicates intact cognition.</p> <p>The care plan initiated 4/10/24 identified resident #1 had Diabetes Mellitus and implemented goals and interventions that included medications as ordered by doctor and fasting serum blood sugar as ordered by doctor.</p> <p>The original physician order/start date written on 3/28/24 by the Physician Assistant with an end date of 4/22/24 read Insulin Lispro Injection Solution Lispro Insulin inject subcutaneously before meals & at bedtime per sliding scale PRN (as needed), inject as per sliding scale; if 151-299 = 2 units into skin as per sliding scale; less than 151 = 0 units; 201-250 = 4 units; 251-300 = 6 units; 30-350 = 9 units; 351-400 = 11 units; greater than 400 give 12 units and call MD, subcutaneously as needed for DM (Diabetes Mellitus) AC/HS (before meals and Hour of sleep).</p> <p>(continued on next page)</p>

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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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MARTAR (Medication Administration Record/Treatment Administration Record) for the month of April 2024 had the order listed but there were no documented blood sugar results recorded or insulin administered recorded. The DON (Director of Nursing) provided a list of completed blood sugars documented elsewhere in the chart as follows:</p> <p>4/1/24 Blood sugar recorded as 299</p> <p>4/3/24 Blood sugar recorded as 301</p> <p>4/5/24 Blood sugar recorded as 206</p> <p>4/17/24 Blood sugar recorded as 289</p> <p>4/18/24 Blood sugar recorded as 158</p> <p>4/20/24 Blood sugar recorded as 226</p> <p>4/21/24 Blood sugar recorded as 266</p> <p>4/23/24 Blood sugar recorded as 144</p> <p>Per the physician order for April 2024 there should have been blood sugars completed four times daily starting on 3/28. Only 8 blood sugar checks were documented and of the 8 documented, 7 should have received coverage with insulin and did not.</p> <p>On 4/23/24 at 2:30 p.m., in an interview with Staff A, LPN (Licensed Practical Nurse), said she had been at employed at the facility for about 6 months now. She said she does not remember ever checking Resident #1 blood sugar before. She looked it up on the computer and said it was only scheduled for morning and evening. She pulled up all the completed blood sugars for April 2024 and there were only 8. She said there should be more blood sugars documented but he refuses treatment a lot so that may be why. She was unable to find documentation of his refusal of blood sugar checks. The last blood sugar documented for Resident #1 was this morning and it was 144.</p> <p>On 4/23/2024 at 3:05 p.m., the DON and the ADON (Assistant Director of Nursing) were asked about the physician order for insulin and the blood sugars not being documented. The DON said she was unsure what the issue was but would investigate and let me know.</p> <p>On 4/23/2024 at 4:30 p.m., the DON said the order for sliding scale insulin must have been entered into the system incorrectly because it was not showing up for the nurses to perform the blood sugar test and administer if needed the ordered dose for insulin. She said the order was written PRN (as needed) from the hospital and that is how it was written and resumed at the facility. There were several PRN blood sugars obtained but that has now been discontinued by the Physician.</p> <p>On 4/24/2024 at 12:20 p.m., in an interview with the Regional Nurse, she said Resident #1 medical record had been reviewed and they could not find any documentation that the blood sugar tests performed were covered with any insulin as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/24/2024 at 4:05 p.m., in an interview with the Primary Care Physician Assistant, she verified that she wrote an order for sliding scale insulin coverage for Resident #1. She verified that his blood sugar was supposed to be monitored daily and medicated with insulin if out of normal ranges. She was unaware that the resident had not been monitored using accucheck (blood sugar check) and that when his blood sugar was checked and found to be elevated that he was not administered insulin. She cannot explain how it happened. She said, maybe it got entered into the computer incorrectly.</p> <p>On 4/25/24 at 9:30 a.m., in an interview with the Administrator and Regional Nurse, they said they had identified the issue on 4/23/24 (after the surveyor brought it to their attention) and started a PIP (Performance Improvement Project) for inputting sliding scale and adding supplementary documentation. They have had Ad Hoc meeting to address issues, audited all residents requiring sliding scale Insulin, and educated staff.</p>		