STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105507	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at North Fort Myers	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49527 Based on record review, resident and staff interviews, the facility failed to obtain necessary medical follow-up appointment for 1 (Resident #2) of 3 residents reviewed. The findings included: Review of the facility policy and procedure titled, Medical Consultations with a revision date of 8/24/2017 showed, The medical staff requesting a consultation will order the consultation and a Request for Consultation will be initiated by nursing to the consulting physician . The consultation will include the examination of the resident and the medical record . The attending will need to note in his re-certification notes that consultation occurred and the outcome of this. On 7/1/24 at 10:55 a.m., in an interview Resident #2 said she had a mammogram done on 5/1/24. She said she already had a biopsy before coming to the facility but needed another one. Resident #2 stated, I'm scared and started crying. She said, I don't know why they are not making an appointment for me. Resident #2 said she has told staff that her breast hurts and needed the biopsy done. Clinical record review revealed Resident #2 was admitted on [DATE]. Diagnoses included localized enlarged lymph nodes, and muscle weakness. The Admission Minimum Data Set (MDS) assessment with a target date of 3/27/24 showed Resident #2's cognition was intact with a Brief Interview for Mental Status (BIMS) score of 15. Review of Resident #2's Care Plan initiated on 4/23/2024, showed the resident had cellulitis (skin infection) of the left breast. Interventions included administer antibiotic as per physician's orders dated 4/23/24. Review of Advanced Practice Registered Nurse (APRN) Staff A progress note with an effective date of 5/2/2024 at 11:36 a.m., showed, Orders placed to arrange outpatient mammogram due to suspected malignant process. Continue to monitor WBC[white blood cell]/temperature curve. On 5/3/24 at 1:47 p.m., APRN Staff A documented in a progress note, Completed outpatient mammogram inconclusive. Requires biopsy. Unit secretary will make arrangements. May need outpatient follow up with surgical oncologist. (continued on next page)

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	On 5/13/24, APRN Staff A documented recommending repeat mammogram in 6 months. Referral provided to two different breast surgeons. On 5/14/24 the Director of Nursing (DON) documented APRN Staff A dropped off the report from a mammogram study done on 5/1/24. She provided the report to Licensed Practical Nurse (LPN) Staff H to secure an appointment for Resident #2 for continuum of care. On 5/21/24 LPN Staff H documented calling, (name) Health Cancer and was awaiting a call back. No other progress note was found in the electronic and physical clinical record related to the follow up appointments with the breast surgeon for Resident #2 as requested by APRN Staff A. Further review of the clinical record showed APRN Staff B visited Resident #2 on 4/5/24, 4/16/24, 4/23/24, 5/10/24 and 7/1/24. The practitioner's progress notes did not address the abnormal findings to the resident's left breast and follow up appointment with the breast surgeon. On 7/2/24 at 9:15 a.m., in an interview APRN Staff B said Resident #2 needed the follow up for her left breast. APRN Staff B said LPN Staff H told her the cancer center will not see the resident while she was at a nursing facility and had a conversation in passing about it with Resident #2. APRN Staff B verified she did not document the conversation with Resident #2 or LPN Staff H and said, I trust my staff. On 7/2/24 at 9:25 a.m., in an interview LPN Staff H said the Cancer center told her they would not see or treat Resident #2 if she had cancer while she resided at the facility but she did not document her conversation. LPN Staff H verified the lack of documentation the facility followed through and obtained a follow up appointment with the breast surgeon for Resident #2. On 7/2/24 at 9:40 a.m., in an interview the Director of Nursing (DON) verified the lack of documentation that the facility obtained the follow-up appointment with the breast surgeon for Resident #2. She said her expectation was for the scheduler to document all attempts to schedule appointments with outside providers in the resident's clinical record, including who she spoke with. The DON said she reviews the progress notes every morning and discusses them with the Interdisciplinary Team. On 7/2/2024 at 9:50 a.m., in an interview the Administrator said he expects staff to document in the electronic health record when trying to make appointments.