STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105558	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at West Palm Beach	5065 Wallis Road West Palm Beach, FL 33415

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38212 Based on interview, observation, and record review, the facility failed to provide toenail care, in a timely manner for 1 (Resident #67) of 1 resident reviewed for foot care. The findings included: Resident #67 was admitted to the facility on [DATE] with diagnosis in part to include: End stage Renal Disease with dependence on renal dialysis, unspecified Protein Calorie Malnutrition, Atrial Flutter, Bilateral Non Pressure Wounds of Lower Extremities, Anemia, Hypertension, Major Depressive Disorder and difficulty in walking. On 03/07/24 Resident #67 had an MDS (Minimum Data Set) assessment. The resident had a BIMS (Brief Interview for Mental Status) of 15, which indicates the resident is cognitively intact. The assessment also indicated the resident needed assistance with bathing, dressing and putting on and taking off footwear. On 05/28/24 at 1:50 PM, an interview was conducted with Resident #67. The resident was sitting outside in a wheelchair. He was wearing sandals. His toenails were observed. His right and left foot toenails were long. On the left foot on the 2-digit the toenail was curving down into his foot. The resident stated they hurt, and he stated he has told the nursing staff he wants them clipped. Photo evidence obtained with consent from Resident #67. He stated he wears sandals because his toenails hurt too much to put shoes on his feet. The orders were reviewed. When the resident arrived on 12/21/23 an order was written for Podiatry, as needed. On 05/29/24 at 7:58 AM, an interview was conducted with the MDS Coordinator. She was asked about Resident #67's toenails and why they had not been cut/trimmed. She stated they were working on it through the VA. In review of the record an order was written on 05/28/24 at 6:30 PM for podiatry consult for ingrown toenails after surveyor interview of Resident #67 on 05/28/24 at 1:50 PM. On 05/30/24 at 12:16 PM the MDS Coordinator was asked who is responsible for the residents getting their toenails cut/trimmed. She stated it is up to the nursing staff. She stated she thinks Resident #67 had previously been on a list for podiatry care at the facility. She stated she was looking for the documentation. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/30/24 at 12:18 PM Resident #67 was interviewed. He stated he has never had his toenails cut/trimmed since he arrived at the facility, and they had not been cut or trimmed anywhere else which includes the VA. He stated he has been asking the nurses and CNAs to cut/trim his toenails for the last 2 months. On 05/31/24 at 7:40 AM Staff E, a CNA (Certified Nursing Assistant) was interviewed. She was asked about residents and cutting/trimming fingernails and toenails. She stated she can cut the nails unless they are diabetic or have another problem. Then she would notify the nurse. On 05/31/24 at 7:50 AM Staff F, a CNA was interviewed. She stated if a resident needed their nails cut/trimmed and if she was unable to cut them, she would notify the resident's nurse. On 05/31/24 at 10:10 AM, an interview was conducted with Staff G, an LPN (licensed Practical Nurse). She stated if a resident needs to have a podiatry consult for nailcare then she can get a consult for the resident. In review of Resident #67's plan of care, he was assessed for an ADL (Activity of Daily Living) selfcare deficit. The intervention dated 01/01/24 was for showering/bathing and documents to check nail length and trim and clean on bath day as necessary. Report any changes to the nurse. During the survey, no documentation was located to indicate Resident #67 had a previous consult for nail care.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 39026 Based on observation, interviews and record review, the facility failed to assess and provide Range of Motion (ROM) as requested by the resident for 1 of 1 resident reviewed for ROM (Resident #53). The findings included: Resident #53 was admitted to the facility originally on 08/24/22. Diagnoses included Guillain-Barre Syndrome, Type 2 Diabetes, Osteoarthritis, and Paraplegia. Her Brief Interview for Mental Status (BIMS) score was 15 on the quarterly Minimum Data Set (MDS) with an assessment reference date of 04/26/24. Section O of the MDS revealed she has not received Physical therapy (PT), Occupational therapy (OT) or ROM in the last 7 days. Section GG of the MDS revealed her functional abilities was limitation in ROM on both sides. On 05/28/24 at 1:25 PM, an interview was conducted with Resident #53. She stated she was in the facility because she never recovered from Guillain-Barre. Guillain-Barre causes your immune system to attack your nerves, leading to symptoms such as weakness, tingling, numbness, and paralysis. She stated she feels like if she does not have ROM she will get weaker. A review of the resident's Physician orders revealed an order for Physical therapy evaluate and treat dated 08/10/23. A review of the resident's care plan with a focus of Acute/Chronic pain has an intervention of Rehab services date initiated 09/05/22 and revision on 11/06/23. On 05/31/24 at 9:28 AM, an interview was conducted with the Director of Rehabilitation (DOR). She was asked if the Certified Nursing Assistant (CNAs) perform ROM during personal care. She stated that they have a restorative aide who does ROM. The DOR stated that Resident #53's desire for ROM has not been brought to her attention but she will do a screening today. She has no past record of her having rehabilitation because previous therapies were with the previous company. An additional interview was conducted with Resident #53 on 05/31/24 at 11:05 AM. She was asked if she told any staff member that she would like additional ROM. She stated she told the MDS Coordinator in the different meetings she has had with her. She also stated when her family was in town that she told her that she would like to have more rehab or at least a screening so she can go home. Interview conducted with the MDS Coordinator on 05/31/24 at 11:15 AM. The MDS Coordinator was asked if she was aware that Resident #53 was asking for more rehab. She stated the resident refuses to get out of bed, refuses medication and she is care planned for this. Asked if she has specifically refused a rehab screening because that is not on the care plan and she stated she would have to look at her documentation. The MDS Coordinator did not provide any additional documentation by the end of the survey.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interview, record and policy review, the facility failed to maintain a PICC (Peripherally inserted central catheter) line in a sanitary manner for 1 of 1 resident sampled for PICC lines (Resident #375). The findings included: The facility's policy titled, Catheter Insertion Care effective 1/17/2019 revealed Change midline catheter dressing 24 hour after catheter insertion, every 5-7 days, or if it is wet, dirty, not intact, or compromised in any way. Resident # 375 was admitted to the facility on [DATE] with diagnoses that included Acute Osteomyelitis of the left ankle and foot, Pressure Ulcer of the left heel and Methicillin Resistant Staphylococcus Aureus Infection as the cause of diseases classified elsewhere. A Brief Interview for Mental Status (BIMS) was done on 05/13/24 and the resident scored a 15, which indicated he was cognitively intact. On 05/28/24 at 11:00 AM, Resident #375 was interviewed and a PICC line was observed on the resident's left upper arm. The dressing was covered with a tubular wrap. The resident was asked if the surveyor could look at the dressing under the wrap and he agreed. The dressing was dated 05/09/24 which was the day prior to the admission of the resident to the facility. The resident was asked if anyone had changed his dressing since he was admitted to this facility and he stated that they flush it but had not changed the dressing. Review of the Physician orders for Resident #375 revealed an order to change dressing on admission or 24 hours after insertion and weekly thereafter and PRN (as needed) every night shift every Fri change dressing weekly. Review of the Medication Administration Record (MAR) for Resident #375 revealed three days the dressing was initialed by a nurse as being changed on 05/10, 05/17 and 05/24. On 05/29/24 at 1:55 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the PICC line dressing for Resident #375 was changed yesterday. Discussed that the PICC line dressing was dated 05/09/24 yesterday. The DON was shown the MAR that showed nurses marked the dressing as changed three times. The DON acknowledged that the dressing change was not done on those dates and he will be doing in-services for the nurses.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to adhere to fluid restrictions for 1 of 2 residents reviewed for dialysis (Resident #37). The findings included: Resident #37 was initially admitted to the facility on [DATE]. According to the resident's most recent full assessment, an Annual Minimum Data Set (MDS), date 03/23/24, Resident #37 had a Brief Interview for Mental Status score of 11, indicating that Resident #37 was moderately cognitively impaired and that the resident required setup help only for eating. Resident #37's diagnoses at the time of the assessment included: Anemia, Diabetes, Heart Failure, Hyperkalemia, Peripheral Vascular Disease, Thyroid disorder, Anxiety Disorder, Depression, Chronic Lung Disease, Disorders of Calcium Metabolism, Gangrene, Insomnia, Extrapyramidal and Movement Disorder, Long term use of insulin, Dysthymic Disorder. Resident #37's care plan for nutrition, initiated on 05/27/20 and most recently revised on 04/17/24, documented, The resident has nutritional problem or potential nutritional problem increased nutrient needs related to history of poor diet compliance, as evidenced by End Stage Renal Disease (ESRD) on Hemodialysis (HD), and needs for therapeutic diet. - increased risk for fluid imbalances/weight fluctuations due to HD treatment. 10/23/23: 1000 ml a day fluid restrictions - increased risk for altered hydration status. The goal of the care plan was documented as, Will maintain adequate nutritional status as evidenced by maintaining weight no signs/symptoms of malnutrition and consuming at least 76% of at least 2 meals daily through review date. 05/27/20 with a revision date of 04/11/24 and a target date of 06/29/24. Interventions included: *Fluid restrictions per HD MD clinic1000 ml/day - 720 ml for dietary (240 ml per meal) 280 ml for nursing staff (180 ml/6 oz 7 AM to 7 PM) 100 ml for 7 PM - 7 AM this exclude any supplements Resident #37's care plan for Rejection of Care, initiated on 12/11/20 with a revision date of 04/02/24, documented, Non-compliant with Dialysis fluid restrictions - independent with taking of fluids .May demand that staff provide her with foods/fluids that are not recommended. Aware of the benefit - stability of medical conditions. Family aware. The goal of the care plan was documented as, Medical needs may not be adversely affected by her non-compliance. 12/11/20 with a revision date of 04/11/24 and a target date of 06/29/24. interventions to the care plan included: * Allow the resident to make decisions about treatment regime, to provide sense of control. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Educate resident/resident's representative/ caregivers of the possible outcome(s) of not complying with treatment of care. Resident #37's care plan for Mood and Behavior, 08/07/22 with a revision date of 04/02/24, Resident is alert: frequently request/demand food and fluids not recommended for her due to ESRD - dialysis dependent/fluid restrictions. She is not easily redirected, dismissive, and may be verbally and or physically disruptive - swearing .Refusing to comply with dietary restrictions/Fluid restrictions. interventions included: * Document/report behavior attempt to determine underlying cause. Resident #37's care plan for dialysis, initated 05/27/20 with a revision date of 05/07/24, documented, Dialysis: Hemodialysis secondary to ESRD on Monday, Wednesday, Friday at Dialysis center The goal of the care plan was documented as, will have no signs/symptoms of complications from dialysis 05/27/24 with a revision date of 04/11/24 and at target date of 06/29/24. Interventions included: *Fluid restriction. See POS/MAR Resident #37's orders included: Hemodialysis secondary to ESRD on Monday, Wednesday, Friday at Dialysis center. Chair time at 9:15 AM. Pick up time: 8:00-8:30 AM. Estimated return time 1:45 PM - 3:00 PM. Transportation with VCT - 03/30/24. CCD Renal diet Regular texture, Regular/thin Liquids consistency - all meats fortified: Tuna sandwich and applesauce @ HS. 1000 ml day Fluid restrictions per HD MD. 720 ML Total/Day: 8 oz coffee @ B 8 oz apple juice at L/D Nursing 280 ml Total/Day 7 AM-7 PM: 180ml/6ox 7 PM-7 AM: 100 ml for Hemodialysis related to End Stage Renal Disease - 03/15/24. On 05/28/24 at 12:46 PM, Resident #37 was noted with a 16 ounce Styrofoam cup of water on the over bed table. On 05/29/24 at 7:30 AM, Resident #37 was observed in bed with breakfast in bed. Resident #37 was noted to have a cup with approximately 4 ounces of apple juice and a cup with approximately 6 ounces of coffee and a 16 ounce Styrofoam cup of water on the overbed table. Resident appeared to be confused and not interviewable at the time of the observation and was not able to demonstrate knowledge or understanding of fluid restrictions. On 05/29/24 at 7:35 AM, the MDS Coordinator stated that 11-7 staff responsible for the water at 6 AM and that staff on the 7-3 shift would be passing water again prior to the lunch meal. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/31/24 at 6:38 AM, Resident #37 was observed sitting on right side of the bed. The resident was noted to have a cup with approximately 4 oz of clear fluid, a cup with approximately 4 oz of apple juice and a cup with approximately 8 oz of hot tea on over bed table. At the time of the observation, Resident #37 appeared confused and was not able to demonstrate knowledge or understanding of fluid restrictions. During an interview, on 05/31/24 at 7:01 AM, with Staff C, LPN, when asked about the fluids provided to Resident #37, Staff C replied, every time when someone passes by, she will ask for something to eat and something to drink. After she is done and we try to take it away, she will get angry so we leave it for her. During an interview, on 05/31/24 at 7:06 AM, with the Director of Nursing (DON), when asked about the fluids provided to Resident #37, the DON replied, her fluid came from kitchen, the only time the nurses give fluid is during medications. The dietitian determines the fluid restrictions and how much fluids she can have. She is sneaky, she will go to the vending machine as well and we have to keep telling her that she can't have it. Asked about resident being aware of fluid restrictions, we educate her. On 05/31/24 at 7:20 AM, Staff D, CNA, was observed serving a tray to Resident #37's room for breakfast. It was noted that the resident was being served approximately 4 ounces of apple juice and 6 ounces of coffee, while there was already 4 oz of clear fluid, a cup with approximately 4 oz of apple juice and a cup with approximately 8 oz of hot tea on over bed table. During an interview with Staff D at the time of the observation, when asked about the fluids provided to Resident #37, Staff D replied, that was from 3-11 (referring to the fluids that were already in the room prior to breakfast being served). She is very difficult. When we take her fluids away, she will go to the kitchen and ask for fluids and the Director says that she is alert and oriented, so he gives them. On 05/31/24 at 7:34 AM, the District Manager from the contract company overseeing the kitchen reported to this Surveyor, the CNA came and asked for apple juice, and we gave it to her and we didn't know that it was for the resident (referring to Resident #37). On 05/31/24 at 8:22 AM, Resident appeared to be confused during attempted interview and was unable to demonstrate knowledge of fluid restrictions. During an interview, on 05/31/24 at 9:20 AM, with the Registered Dietitian, when asked about the risks associated with no adhering to the fluid restrictions, the Registered Dietitian replied, fluid overload - she can get worse and cause cardiac arrest due to the fluid overload. Her edema can be exasperated. The main issues is cardiac issues. In the past, she was more oriented and able to understand.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38893 Based on observations, interviews and record reviews, the facility failed to provide foods prepared under sanitary conditions and in accordance with standards for food safety professionals. The findings included: 1). During the initial kitchen tour, on 05/28/24 at 8:48 AM, accompanied by the District Manager for Health Services Group (contracted to oversee the kitchen/dietary) the following were noted: a. An employee's personal cellular device on prep table by the walk in cooler. b. There was an accumulation of food residue on the sharpening stones to slicer. c. A 1/3 sized six inch deep container of barbecued pork in the process of cooling from the previous day was 49 degrees Fahrenheit (F). The District Manager confirmed that the pork was in the process of cooling from being served the day before. d. A 1/3 sized six inch deep container of meatballs in the process of cooling from the previous day was 51 degrees F. The District Manager confirmed that the meatballs were in the process of cooling from being served the day before. e. In the food services area, the wall to the left of the hand washing sink was damaged. f. In the food services area, there was an accumulation of black residue inside of the ice machine. 2). During the follow up tour of the kitchen, on 05/30/24 at 11:01 AM, accompanied by the District Manager and the Account Manager, the following were noted: a. Staff A, Dietary Aide, was observed adjusting glasses that Staff A was wearing. Staff A then proceeded to another area of the food service area to answer a phone call on her personal cellular device, and then placed the cellular device into her back pocket before opening and closing the reach in cooler. As Staff A began retrieving trays through a window from the kitchen to the food service area, this Surveyor intervened and instructed Staff A to perform hand hygiene at the hand washing sink. Staff A and the District Manager acknowledged that Staff A had not performed hand hygiene at any time that the observation was being made. b. There was ice from an unknown source in the only hand washing sink in the food service area. c. Staff B, Dietary Aide, was noted to be wearing loose fitting bracelets while preparing to receive trays from the kitchen to the food services area. d. Staff A was observed handling portioned drinks with bare hands in direct contact with the lip contact surface of the cups.