STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105578	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at the Sea - Harbor Beach	1615 Miami Rd Fort Lauderdale, FL 33316

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31746 Based on observations and interviews, 5 of 14 sampled residents (Resident #4, Resident #14, Resident #19, Resident # 30, and Resident # 33) were noted to be treated in an undignified manner by the facility. The findings included: 1) On 05/06/24 at 1:44 PM, Resident #14 was observed sitting in a wheelchair appropriately dressed in his personal attire. Resident #14's feeding formula was infusing via a tube. The privacy curtain dividing Resident #14 from his roommate, who also was observed in bed eating lunch, was fully opened. Resident #14 could easily see Resident #33's meal and did see Resident #33 eating his lunch. Resident #14 was admitted to the facility on [DATE]. Resident #14 diagnoses included: Cerebral Infarction and Flaccid Hemiplegia affecting right non-dominant side. Resident #14 is fed via peg tube. He is non-verbal and communicates using facial gestures, his hands, and head (nodding yes or no). Resident #14 gestured his displeasure on 05/06/24 at 1:47 PM to question, how do you feel watching your roommate eating? He used his hand to express his emotional feeling gesturing the cutthroat sign. To be sure, the Surveyor asked Resident #14 to gesture like or dislike by head movement. When asked if he liked seeing his roommate eating, he gestured no with head movement, and made a grimacing look of disapproval. He was asked if he would like the curtain closed, he gestured yes with head movement. Review of the physician orders for the month of May 2024 confirmed orders for enteral feeding for Resident #14. The Nursing Care Plan dated 3/21/24 documented that Resident#14 depended on staff for meeting his emotional, intellectual, physical and social needs. 2) On 05/06/24 at 1:19 PM, Resident #33 was observed in bed lying on his back and wearing an institutional or a facility's gown. With the Resident's permission, the Surveyor observed that Resident #33 had personal clothes in his closet. Resident #33 was noted to be non-verbal. He smiled when spoken to but quickly presented a flat affect or non-expressive facial appearance. On 05/06/24 at 1:44 PM during lunch, Resident #33 was observed in bed in a seating position eating but wearing the same gown. Meanwhile, his roommate was observed appropriately dressed and seating in a wheelchair while his meal was being infused. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/07/24 at 2:21 PM, Resident #33 was observed lying in bed wearing a green institutional gown. Resident #33's body rested in a supine position or on his back with his head slightly elevated and watching television. On 05/08/24 at 1:12 PM, Resident #33 was observed wearing a green institutional gown in bed in the same position as previously noted. On 05/09/24 at 1:44 PM, Resident #33 was observed in bed wearing an orange color shirt and laying in bed watching Television. Resident #33 was admitted on [DATE] and his diagnoses included: Cerebral infarction; Flaccid Hemiplegia affecting right nondominant side; Adjustment Disorder; Generalized Anxiety Disorder; Major Depressive Disorder. The Care Plan dated 3/21/2024 showed that Resident #33 depended on staff for meeting emotional, intellectual, physical, and social needs related to disease process. Resident #33 had communication problems related to stroke, he rarely responds verbally. Staff will anticipate his needs and be conscious of the resident's needs. On 05/08/24 at 3:45 PM, an interview with Employee A, a Certified Nursing Assistant (CNA) revealed that she has been working at this facility for two years. She said that they usually float or rotate throughout the facility. She said that Resident #33 has his own clothes. The CNAs who works in the are supposed to dress the patients and when she comes in the afternoon, she would undress the patients and put night gown on them. She said that Resident #33 can eat by himself, but he is not able to turn or transition from lying down to sitting by himself. He cannot speak. Resident #33 tries at times to say some words, but he is not clear. Employee A said that as a CNA they must anticipate Resident #33's needs. 01948 3) During the observation of the lunch meal conducted in the main dining room on 05/06/24 at 12:15 PM, it was noted that Resident #4 was seated at a dining room table with another resident, and also noted that 17 residents were in attendance in the dining room for the lunch meal. Further observation of Resident #4 noted that the resident was served a Consistent Carbohydrate Diet/No Added Salt Diet with Large Portions. Further observation noted that the staff (Staff E) set the meal tray in front of the resident and left to attend to other residents. It was noted that the resident was alert with confusion and begin to eat the entire meal with her bare hands that included Cheesy Ham & Macaroni Casserole , Sauteed Spinach Carrots, and Pineapple Crisp. Further observation noted that there were 4 other staff in the dining area serving and assisting other residents, however no attempt was made by facility staff to intervene and try to supervise the resident utilizing silverware provided on the meal tray. During the meal it was noted the food covered the resident's face, front of chest, table, and floor with spilled foods from eating with bare hands. It was noted that several residents seated near the resident during the meal and complained to staff concerning Resident #4, however no staff responded to the resident's request. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the observation of the lunch meal on 05/08/24, it was again noted that Resident #4 ate the entire meal without staff intervention. Also noted that several residents complained concerning Resident #4, however staff did not respond. Resident was noted to eat Pork Chop, Rice, and Corn with bare hands. Resident again noted to cover face with foods, front of body, table, and floor with spilled foods from eating with bare hands. A review of the clinical record of Resident #4 noted the following: < Date Of Admission: 5/18/21 < Diagnoses: Schizophrenia, Bipolar Disorder, Diabetes Type 2 < Current Physician Orders: * 9/27/21 - CCD/NAS/Large Entree 11/29/21 - Scoop Plate with all meals * Current MDS: 1/27/24 Section B : Usually understood & understands Section C: BIMS = 6 (cognitive impairment) Sec GG: Eat = Set Up Sec K : 67/165# Therapeutic Diet * Weight History: 4/16 = 161 2/6 = 165 1/4 = 171 BMI= 25.2 Ht = 67 Care Plan Review: 3/21/24 * * Assistance Daily Living: scoop plate, *Provide Food from mug or cup - resident refuses or difficulty eating solid foods with solid foods (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) During the observation of the lunch meal in the main dining room of 05/06/24 at 12:15 PM, it was noted that Residents #19 and #30 were served a Pureed Diet by the LPN (Staff D). Further observation noted that the pureed foods were thin, watery, and running over the edge of the entree plate. Further observation noted that the CNA (Staff E) mixed both resident's pureed meal (entree, vegetable, and starch) in a brown slurry mix. The appearance and acceptability of the meal was poor. Further observation noted that Staff D turned to the surveyor and stated aloud in front of Residents #19 and #30 and the rest of the residents I don't know how anyone can eat that crap'. The residents were noted to eat less than 25% of the lunch pureed meal.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948 Based on observation and interview, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 16 of 28 resident rooms, 1 of 2 community shower rooms, main dining room, ice machine room, and 1 of 1 clean linen storage rooms. The findings included: 1) During the observation of the commercial ice machine room which is located in a room just off the main dining room on 05/07/24 at 1 PM accompanied with the Corporate Housekeeping Director (CHD). The floor of the entire room was heavily soiled and stained black in color. Further noted the floor area was missing around the commercial ice machine and there was a large gap under the exit door to the outside that could potentially allow entrance of pests into the facility. Photographic Evidence Obtained. 2) During the observation of the facility's laundry room department on 05/07/24 at 2 PM and on 05/08/24 at 2 PM, accompanied with the facility's Corporate Director of Housekeeping (CDH), the following were noted: * Upon entering it was noted that the door (barrier) between the soiled room and the wash room was wide open. The CDH stated that the air-conditioning stopped working in the laundry department a few days ago and the door is left open for circulation for the employees working within the laundry areas. The CDH stated that the door is required to be closed at all times as a infection control barrier between the soiled and clean area. * The entire floor area of the soiled/sorting room was noted to be heavily soiled, large black stains, and areas of peeling paint. It was discussed with the CDH that the floor is not being properly cleaned on a daily basis. * The exterior of the large ceiling vent in air-intake vent located in the middle of the soiled room were noted to be heavily soiled and rust laden. * Washing chemicals were noted to be stored on wood and paper shelving and it was noted that the wood was covered in a black mold type matter. The floor area underneath the shelving was noted to have a heavy build-up of dirt and dust. It was discussed with the CHD that shelving should not be porous wood and should be metal or hard plastics. Further stated that the floor underneath the shelving is not being properly cleaned on a regular basis. * The walls and window of the soiled room was noted to be dust and dirt laden. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* The floor and walls of the washing machine room was noted to be soiled and covered with a black substance. The floor area in front of the washing machine was noted to have a large area of peeling paint. The area behind the washing machines was heavily soiled with dust and dirt and is not being cleaned on a regular basis. Interview with the CHD noted 1 of the 2 washing machines has not been operational in the last 3 months. They stated administration is aware, however there has been no resolution. * The floor of the clean drying/folding room was heavily soiled and large areas of peeling paint. It was discussed with the CHD that the floor is not being maintained and cleaned on a regular basis. * Interview with the CHD noted that 1 of the 2 commercial dryers has not been operational since October 2023. They stated that the facility administration is aware but no attempt made to resolve the dryer issue. The lint vent of the operational dryer had a heavy build-up of dirt and dust and was not being cleaned per the facility policy of cleaning the lint vent every 2 hours. * The ceiling vent located above the clean linen folding table was soiled and build-up of black mold type matter. It was discussed with the CHD that the vent could contaminate clean clothes located below the vent. * Photographic Evidence Obtained. 3) During the observation of the Main Dining Room conducted on 05/08/24 at 11 AM and accompanied with the Administrator, the following were noted: * The ceiling frame located on the 2 long sides of the Dining Room were noted to have a build-up of yellow/brown matter. The administrator stated that it was old tape from an activity conducted in the dining room. * One of the ceiling light covers located over a dining room table was noted to have a large crack and piece missing. It was discussed with the administrator that the pieces of the cover could potentially fall onto the residents and their food while eating. * One of 5 ceiling light covers was noted to have a build-up of dried dead insects. * Photographic Evidence Obtained. 4) During the resident screening conducted by the surveyors on 05/06/24 and the Environment Tour conducted with the Administrator on 05/08/24 at 11 AM and accompanied with the Administrator the following were noted: * Clean Linen Room: Unlocked and not secured, 4 disposable razors stored on shelving, 12 ounce bottle of Hydrogen Peroxide located on shelf, room floor and walls (4) heavily soiled and stained. Interview with the Administrator at the time of the observation noted that the room is not being properly cleaned or secured on a regular basis. * room [ROOM NUMBER]: Exterior of over-bed tables (2) noted to be soiled and areas of peeling paint, room floors and walls soiled and in disrepair, and disposable razor on floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* room [ROOM NUMBER]: Exterior of over-bed tables (2) noted to be soiled and areas of peeling paint, heavily rusted bed frame (Bed-2), Electric Bed not working (Bed-1), and room walls scuffed and in disrepair. * room [ROOM NUMBER]: Room floor and wall base boards soiled, stained, and in disrepair. room [ROOM NUMBER]: Large area room wall damage, IV pole and base heavily soiled and rust laden, privacy curtains (2) areas of dried brown matter, bathroom floor soiled and stained black, bathroom emergency call light activation cord wrapped around the wall hand rail. room [ROOM NUMBER]: Exterior of bed frame rust laden (Bed-1) , exterior of over-bed tables (2) soiled and areas of peeling paint, room walls and floors heavily stained and soiled. room [ROOM NUMBER]: Room baseboards missing, large hole in room walls, room floor and walls soiled and in disrepair. room [ROOM NUMBER]: Bathroom emergency call pull cord wrapped around bathroom hand rails, exterior of over-bed tables soiled and areas of peeling paint, bathroom noted offensive urine odor. room [ROOM NUMBER]: Bathroom toilet continuously running, bathroom toilet paper holder broken off of wall, exterior of over-bed tables soiled and areas of peeling paint, bedside table missing bottom drawer (Bed -1). Community Shower: Three of 4 ceiling lights not working. Biohazard Room: Internal cavity of specimen refrigerator had a heavy ice build-up. room [ROOM NUMBER]: Exterior of bathroom door damaged and in disrepair, bathroom emergency call light cord wrapped around handrail, exterior of over-bed tables (2) soiled and areas of peeling paint. room [ROOM NUMBER]: Walls soiled, damaged, and in disrepair. room [ROOM NUMBER]: Walls soiled, damaged, and in disrepair, room closet wardrobe closet missing door opening knobs,(Bed-1), pull chain for over-bed light missing (Bed-1). room [ROOM NUMBER]: Privacy curtains (2) soiled with dried brown matter, and room walls soiled, damaged, and in disrepair. room [ROOM NUMBER]: Offensive urine odor coming from room into resident hallway, and room walls soiled, damaged, and in disrepair. room [ROOM NUMBER]: Room walls soiled, damaged, and in disrepair, and bathroom toilet noted to be black stained and requires re-caulking to the floor, room [ROOM NUMBER]: Two large holes in room wall, bathroom door opening handle broken, bathroom walls and tiles stained black, and exteriors over-bed tables (2) soiled and areas of peeling paint. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER]: Poor TV reception (Bed-2) , room walls soiled, damaged, and in disrepair, and exterior of over-bed tables soiled and areas of peeling paint. Outdoor Patio: Numerous (5) large potted plants noted to be dead, entire floor area noted to have peeling paint, and rust laden wall fan, large hole at the entrance exit door (12 inches across by 3/4 inch deep - trip/fall hazard). Following the 05/08/24 Environment Tour the findings were again reviewed and confirmed with the Administrator, and were also discussed with the facility's Corporate District Manager. It was discussed that the facility does have a computerized TELS system for reporting of housekeeping and maintenance issues , however staff require retraining of the system. It was also noted that there is a Housekeeping/Maintenance Log located at the Nurses Station for staff to report issues. Further stated staff are not reporting and documenting housekeeping and maintenance requests.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31746 Based on records review and interviews, the facility failed to investigate an incident in which 1 of 1 sampled resident (Resident #15) sustained injuries of unknown origin. The findings included: Resident #15's electronic clinical record revealed he was readmitted to the facility on [DATE] and an initial admitted [DATE]. Resident #15 diagnoses included: Dislocation of left shoulder joint; Anxiety Disorder; Atherosclerotic Heart Disease; Type 2 Diabetes Mellitus; Osteoarthritis; Muscle weakness; Cognitive communication deficit; Difficulty walking; Convulsion; Depression; Localized swelling to left upper limb; History of falling. The Nurses' Progress Notes (NP's) dated 4/14/2024 at 7:07 AM, noted that Resident #15 was complaining of left-hand pain and swelling. the MD was notified, and an X-Ray was ordered. Another NP's notes dated 4/15/2024 documented that order received to send the resident to hospital for higher level of care and altered mental status. The 4/16/2024 NP's notes revealed that Resident #15 was hospitalized . None of the NPs' notes documented that Resident #15 had a fall injury. In fact, the NPs report did not document how the fall occurred. There was no indication of a comprehensive nursing assessment detailing Resident #15's pain level or injuries. Review of the SNF to Hospital transfer form dated 04/15/2024 revealed that Resident #15 had a fall on 4/13/2024. Staff documented bilateral shoulder pain to identify pain location. During an interview with the Regional Minimum Data Set (MDS) Coordinator on 05/09/24 at 10:03 AM, she reported that an X-ray was ordered on 4/14/2024 for Resident #15. She provided the evidence which outlined Resident #15's possible pain level. Review of the Radiology Results Report dated 4/14/2024 revealed an order to have 2-views of Resident #15's left elbow. The report further revealed that due to Resident #15's level of pain only a single frontal view of the left elbow could be performed. The single frontal view of the left elbow X-Ray showed no abnormalities. Recommendation was made to have additional views to better assess the resident's physical condition when Resident #15 could tolerate a lateral positioning of the arm. The hospital record dated 4/20/2024 documented that Resident #15 sustained a shoulder dislocation as per diagnoses listed in the record which included: Generalized weakness; Fall; Shoulder dislocation. Also, the record noted that Resident #15 had left shoulder dislocation reduced in ED (emergency department) on 04/16/2024, the exact date Resident #15 was transferred to the hospital. As per Orthopedic, Resident #15 was non-weight bearing on the left upper extremity. During an interview with the Director of Nursing (DON) on 05/09/24 at 11:45 AM, she said that she did not have any record of the resident injuring his shoulder while at the facility. she only had record of Resident #15's fall which occurred on March 6, 2024 which was a fall resulting in no injuries. When questioned further, the DON said that she did not conduct an investigation on the cause of Resident #15's transfer to the hospital. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Social Service Director (SSD) on 05/09/24 at 1:32 PM, she reported that Resident #15's brother had planned for the resident to be discharged home on 4/11/2024. The SSD said that she had to inform Resident #15's brother, when she returned to the facility on [DATE] that Resident #15 had a fall and was sent to the hospital. The SSD said that one of the nurses had reported the incident to her. On 05/09/24 at 3:06 PM, an interview with Staff B, a Licensed Practical Nurse (LPN) who completed the SNF-to hospital transfer from and assessment confirmed that Resident #15 had a fall at the facility and was injured. Staff B said that during the assessment, Resident #15 guarded his shoulder and complained of severe pain. Staff B said that he spoke with Resident #15's brother and informed him that resident was sent to the hospital for altered mental status. Staff B added that Resident #15 wandered at times and said inappropriate things. Staff B was not sure how Resident #15's injuries occurred. Staff B said contrary to what he erroneously documented, Resident #15's pain level was not zero. Staff B said that he had reported the transfer and injuries to the facility's DON. The DON had inquired about Resident #15's vitals signs and who Staff B had notified.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 01948 Based on observation, interview, and record review, it was determined that the facility failed to provide assistance and supervision to maintain independent eating abilities for 2 (Resident #5 and #13) of 6 sampled residents reviewed for nutrition. The findings included: 1) During the observation of the breakfast meal of 05/08/24 at 8:30 AM, it was noted that the meal tray was observed to be delivered to the room of Resident #5. Continued observation noted that the resident was visually impaired but alert. Continued observation noted that the Certified Nursing Assistant (CNA- Staff E) set the tray on the resident's overbed table in front of the resident who was noted to be in a reclining position in the bed. The CNA failed to speak with the resident concerning where foods could be located on the meal tray or reposition the resident into an upright eating position in the bed. Further observation noted the CNA to leave the room and not return to give the resident supervision or assistance with the meal. The resident was noted to struggle to find foods on the meal tray and would utilize bare hands with pureed hot and cold tray foods. The resident was noted to get increasingly agitated and yelling out for assistance with eating. At 9 AM the CNA returned to the resident's room and took the meal tray away with the resident consuming less than 25% of the meal. A second observation conducted on 05/08/24 at 12:30 PM, and again noted the pureed meal served to the room of Resident #5. Continued observation again noted the meal tray was set up on the overbed table in front of resident and the CNA left the room. Continued observation for the next 30 minutes noted no nursing staff entering the room to supervise or assist the resident with the lunch meal. Resident noted to be eating pureed foods with bare hands resulting in spilling pureed foods on body, bed, and floor. At one point during the observation the straw provided in the cold beverage became lodged into the resident's mouth and was noted to struggle to remove. The surveyor intervened and helped remove the straw to prevent choking. It was again noted that the CNA removed the tray with the resident consuming less than 25% of the lunch meal. Review of the clinical record of Resident #5 noted the following: * Date of Admission: 4/23/21 * Re-admission: 3/19/24 * Diagnoses: Legal Blindness, Post Traumatic Stress Disorder, Gastrostomy Disorder * Current Physician Orders: 5/7/24 - Osmolyte @75 ml/hr X 20 hours - on at 2 PM - off @10 AM 5/7/24 @ 8 AM - Osmylyte 75 ml/hr running (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/7/24 - Flush water @ 25 ml /hr X 20 hr 4/27/24 = Dysphagia Pureed Diet * Current MDS: 3/24/24 < Section B: Understood & Understands < Section C: BIMS = 13 (alert & oriented < Section D: No Mood Issues < Section GG: Supervision & Assistance < Section J : 67/170# < Feeding Tube/Mechanically Altered Diet * Review of current Care Plan : 03/24/24 < Requires Tube Feeding < Nutritional Problem - Risk For Malnutrition * NO interventions for assistance with independent with eating < Visual Impairment * No interventions for eating * Weight History : < 4/11/24 = 160# < 3/28/24 = 165.5# < 02/23/24 = 170# < 9/8/23 = 172# < 8/11/23 = 174 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105578	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at the Sea - Harbor Beach	1615 Miami Rd Fort Lauderdale, FL 33316

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) During the observation of the breakfast meal of 05/08/24 at 8:35 AM, it was noted the meal tray was served to the room of Resident #13. It was also noted that Resident #13 resides in the same room as Resident #5 and was also noted to be visually impaired and alert. Continued observation noted the resident to struggle finding foods located on the tray and ate with hands/fingers. The resident was noted to request assistance but the room door was shut and no staff were noted to assist or supervise the resident with the breakfast meal. The meal was taken away approximately 30 minutes later and it was noted the resident to consume less than 50% of the breakfast meal . A second observation conducted for the lunch meal of 05/08/24 at 12:30 PM noted the Consistent Carbohydrate/No Added Salt diet meal tray was already served to the room of Resident #13. The observation noted that the tray was set up on the resident's overbed table, however the resident was laying flat in the bed and was naked from the waist down. The resident was noted to be visually impaired and was reaching up from the bed over the overbed table and into the meal tray. The resident was noted to grab whatever foods she could and drop foods into her mouth. Spilled foods were noted all over the resident's face, body, and bed. At this time, the surveyor summoned the Director of Nursing (DON) to the resident's room to view the surveyor's observations. The DON confirmed the surveyor's findings and stated that all nursing staff would require in-service training on providing Resident #5 and #13 with assistance and supervision with all meals. During the review of the clinical record of Resident #13, the following were noted: * Date of Admission: 4/9/21 * Re-Admission: 8/15/21 * Diagnoses: Legal Blindness /Glaucoma * Current Physician Orders: < 10/1/21 - Carbohydrate Controlled Diet/ No Added Salt Diet < 3/24/23 - Fortified Food at Lunch < 12/13/21 - Scoop Plate < 10/1/21 - HS Snack < 9/19/23 - Dietary Counseling/Surveillance * MDS: 3/20/24 Section B : Understood & Understands Section C : BIMS = 13 (some cognitive impairment) Section D: Depressed Mood/Sec GG: Set Up - Assistance Section K: No Swallow Disorder (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	67/137# Weight History: 4/26/24 = 137# 1/3/24 = 139# 10/25/23 = 143# 9/8/23 = 150# Ht = 67 BMI = 21.5 Care Plan Review : 1/13/23 * Nutritional Problem-Resident is Legally Blind * No documented intervention of maintaining independence of eating with blindness. * Self Care ADL Deficit: * Able to feed with set up and assistance , requires scoop plate. * Requires and provide food from mug - difficulty with solid food. Following the Care Plan review with the Director of Nursing on 05/08/24, it was noted that the dietary and nursing staff were unaware of the care plan intervention to provide all foods in mugs to maintain independence with eating. Also discussed no interventions of assistance with eating during meals with diagnoses of blindness.

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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 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** 31746 36734 Based on observation, interview, and record review, the facility failed to identify and treat a resident with Diabetes for 1 of 1 resident reviewed for insulin (Resident #17). The findings included: Resident #17 was admitted to the facility on [DATE] with diagnoses which included Diabetes Mellitus Type 2 and a Diabetic foot ulcer. A comprehensive assessment dated [DATE] documented the resident was cognitively intact (15/15 Brief Interview for Mental Status), and required partial/moderate assist for activities of daily living. The assessment further documented Resident #17 had not received any injections (insulin) since admission to the facility. Record review revealed Resident #17 was care planned for Diabetes, with an intervention to medicate as ordered. A review of Resident #17's orders on 05/08/24 revealed Resident #17 did not have any medications for Diabetes, nor any fingersticks or lab results indicating the resident's blood sugar levels. An interview was conducted with Resident #17 on 05/08/24 at 11:00 AM. The resident was observed ambulating to her room. Resident #17 stated she was concerned because she was not receiving any insulin, or getting her blood glucose levels checked. The resident stated she was a Diabetic, and had received insulin while in the hospital prior to admission to the facility. Resident #17 further stated she had brought it up to staff/nurses, and was told they needed an order to check the resident's blood sugar. An interview was conducted with the Director of Nursing (DON) on 05/08/24 at 11:20 AM. The DON confirmed Resident #17 had a diagnosis of Diabetes. The DON further confirmed the resident did not have any orders for fingersticks or labs to monitor the resident's blood glucose, nor any medication to treat the resident's Diabetes. A progress note dated 05/08/24 at 12:10 PM by the DON documented: Spoke with MD in regard to patient concern with BS levels, lab, and diagnosis. Orders received for stat labs, Lispro (insulin), Lantus orders (insulin), Metformin (diabetic medicine), and blood sugar checks daily. An interview was conducted with Resident #17 on 05/08/24 at 12:30 PM. The resident stated they checked her blood sugar and it was 446 (normal is 74-109). An interview was conducted with the DON on 05/08/24 at 1:00 PM. The DON confirmed Resident #17's blood sugar was 446, the resident received insulin and the physician had ordered diabetes medication and stat labs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Medical Director of the facility, who was also the Resident #17's Primary Care Physician (PCP) while at the facility, on 05/08/24 at 2:30 PM. The PCP stated, It's very horrible that the resident fell through the cracks. The PCP stated the resident refused labs at one time, but he did not follow up with it. The PCP stated the resident did not refuse accuchecks/fingersticks, as none were ordered. The PCP stated nothing was communicated to him about the resident requiring or asking for her blood sugar to be checked. All the staff had to do was call him. The PCP stated, We'll take care of her now. An interview was conducted with Staff F, a Licensed Practical Nurse, on 05/08/24 at 2:35 PM. Staff F stated he was Resident #17's primary nurse, and had cared for the resident before. When questioned by the surveyor if he knew the resident was a Diabetic, he stated, No, because the resident did not have any medications ordered for Diabetes. Staff F further stated Resident #17 did not ask him to check her blood glucose level.

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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. 31746 Based on observations, records review, and interviews, the facility failed to provide physician's ordered left hand splint to 1 of 1 sampled resident (Resident #14). The findings included: On 05/06/24 at 12:48 PM Resident #14 was observed in bed lying in supine position with contracted left hand and having no splint on. Resident #14 was alert, aware, but non-verbal. Review of the physician's orders dated 12/17/2022 revealed the following order: left hand splint to be worn up to 6 hours, 7 days a week. Apply left elbow splint up to 6 hours 7 days a week. Another order noted: Left Elbow Splint as tolerated, may remove for ADL care or skin checks. Also, Resident #14 to wear Carrot on left hand at all times except for hand hygiene and bathing. Resident #14's diagnoses included, Hemiplegia and hemiparesis following Cerebral Infarction Affecting left non-dominant side; Muscle weakness generalized; Amyotrophic lateral sclerosis; Contracture left ankle; Anxiety Disorder; Ankylosis left wrist; Mild Cognitive impairment of unknown etiology; Ataxia; Irritant Contact Dermatitis; Progressive Bulbar Palsy; Foot Drop left foot; Dysarthria and Anarthria. Review of the Care Plan dated 1/25/2024 documented that Resident #14 continues to wear adaptive devices related to contracture treatments prevention. Patient has a Left Lower Extremity brace. Patient has a Left upper extremity slim grip to the left wrist. Patient continues to wear adaptive devices related to contracture, treatment/prevention. Resident wears a splint on the left upper extremities. The Minimum Data Set (MDS) section C documented Resident #14 obtained a score of 11/15 on the brief interview for mental status (BIMS). Resident #14 nodded when interviewed on 05/07/24 at 3:00 PM that they did not put the splints on for him on 5/6/24. He gestured and also pointed out to where the splints were. The location Resident #14 pointed to was the dresser. On 05/08/24 at 12:39 PM Resident #14 was observed sitting in his wheelchair appropriately dressed wearing a left elbow splint and ankle brace, but Resident #14 had no wrist splint on. Resident #14 affirmed with a negative head nod that they do not put the wrist splint on for him. On 05/08/24 at 2:44 PM Resident #14's Power of Attorney (POA) informed that Resident #14 has been ill since 2013 and has resided at this facility since 2016. The POA said not all staff are as attentive to Resident #14's health needs as they should have been. The POA stated some of the staff put the splint on some do not. The POA also said that Resident #14 is very alert and his mind is very sharp. Resident #14 understands everything, but he is just a little forgetful, at times. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/24 at 3:54 PM, Staff A said that she has been working at this facility for two years. She said that they usually float and rotate throughout the facility. Staff A works 3-11 PM shift. She said that Resident #14 is on tube-feeding, he wears a splint; he is totally dependent for his care. She said that the splints are used to prevent contractures. Staff A said that Resident #14 has an elbow splint on the left arm and one ankle splint. He does not have any other splint. When questioned about the hand/wrist splint. Staff A said that Resident #14 used to have a hand splint but they do not use it anymore. Staff A added that sometimes they put it, sometimes, they do not. Staff A said that she does not put the wrist splint for Resident #14. The Certified Nursing Assistant (CNA) who works in the morning usually does it. Lastly, Staff A said that the facility used to have a restorative nurse responsible for that assignment, but that responsibility was now assigned to the CNAs.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on record review and interview, the facility Physician failed to identify and treat a resident with Diabetes for 1 of 1 resident reviewed for insulin (Resident #17) and failed to address a critical lab result for 1 of 1 sampled resident (Resident #157). The findings included: A review of the facility's Policy and Procedures Medical Care/Standards of Practice, dated 11/30/2014 and revised on 03/03/21, documented: A physician supervises the medical care of each resident. Physician supervision includes but is not limited to: Admission orders are consistent with the resident's current physical and mental status. No medications or treatments shall be given without a doctor's order. Whenever possible, each of the resident's clinical problems should be clearly identified in the progress notes and correlate with specific orders as well as results of tests and treatments. 1. Resident #17 was admitted to the facility on [DATE] with diagnoses that included Diabetes Mellitus Type 2 and a Diabetic foot ulcer. A comprehensive assessment dated [DATE] documented the resident was cognitively intact (15/15 Brief Interview for Mental Status), and required partial/moderate assist for activities of daily living. The assessment further documented Resident #17 had not received any injections (insulin) since admission to the facility. Record review revealed Resident #17 was care planned for Diabetes, with an intervention to medicate as ordered. A review of Resident #17's orders on 05/08/24 revealed Resident #17 did not have any medications for Diabetes, nor any fingersticks or lab results indicating the resident's blood sugar levels. Further record review revealed Resident #17 had been seen by the physician 6 times since admission (04/13/24, 04/15/24, 04/17/24, 04/22/24, 04/24/24, and 04/29/24). A review of the physician progress notes did not address Resident #17's diagnosis of Diabetes. An interview was conducted with Resident #17 on 05/08/24 at 11:00 AM. The resident was observed ambulating to her room. Resident #17 stated she was concerned because she was not receiving any insulin, or getting her blood glucose levels checked. The resident stated she was a Diabetic, and had received insulin while in the hospital prior to admission to the facility. Resident #17 further stated she had brought it up to staff/nurses, and was told they needed an order to check the resident's blood sugar. An interview was conducted with the Director of Nursing (DON) on 05/08/24 at 11:20 AM. The DON confirmed Resident #17 had a diagnosis of Diabetes. The DON further confirmed the resident did not have any orders for fingersticks or labs to monitor the resident's blood glucose, nor any medication to treat the resident's Diabetes. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Medical Director of the facility, who was also the Resident #17's Primary Care Physician (PCP) while at the facility, on 05/08/24 at 2:30 PM. The PCP stated, It's very horrible that the resident fell through the cracks. The PCP stated the resident refused labs at one time, but he did not follow up with it. The PCP stated nothing was communicated to him about the resident requiring or asking for her blood sugar to be checked. The PCP acknowledged he had seen Resident #17 5 times since admission to the facility. The PCP further stated he shared the blame in Resident #17's lack of care related to the diagnosis of Diabetes. All the staff had to do was call him. The PCP stated, We'll take care of her now. 2. Resident #157 was admitted to the facility on [DATE] and discharged to the hospital on 12/15/23, with diagnoses that included Cirrhosis of the Liver and Liver Cancer. Record review revealed a laboratory critical low value Platelet level of 32 (normal is 130-400) dated 12/07/23. Further record review revealed the critical value was not addressed. Resident #157 was seen by the physician 3 times during the stay at the facility (12/06/23, 12/11/23, and 12/13/23). A review of the physician progress notes did not address Resident #157's critical low platelet count.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on record review and interview, the facility Physician failed to document visits in a timely manner for 2 of 2 sampled residents (Resident #17 and Resident #157). The findings included: A review of the facility's Policy and Procedures Medical Care/Standards of Practice, dated 11/30/2014 and revised on 03/03/21, documented: Physician visits are required according to the resident's needs and/or State and Federal guidelines. A physician visit is required within 48 hours of admission. For short term care, a physician must see the resident as often as medically necessary according to the medical status of the resident. It is recommended physician visits occur two or three times per week due to the medical complexity of the resident. Medical records must be maintained according to all state and federal requirements and in compliance with all center policies and procedures. The attending physician shall maintain his portion of the medical record, timely, in accordance with the center, State and Federal regulations and requirements. Progress notes will be recorded at the time of observance, sufficient to permit continued continuity of care and transferability. 1. Resident #17 was admitted to the facility on [DATE] with diagnoses that included Diabetes Mellitus Type 2 and a Diabetic foot ulcer. A comprehensive assessment dated [DATE] documented the resident was cognitively intact (15/15 Brief Interview for Mental Status), and required partial/moderate assist for activities of daily living. The assessment further documented Resident #17 had not received any injections (insulin) since admission to the facility. Record review revealed Resident #17 had been seen by the physician 6 times since admission (04/13/24, 04/15/24, 04/17/24, 04/22/24, 04/24/24, and 04/29/24). Further review of Resident #17's physician progress notes revealed: Progress note dated 04/13/24 was created on 12/19/23 as a late entry. Progress note dated 04/15/24 was created on 04/20/24 as a late entry. Progress note dated 04/17/24 was created on 04/27/24 as a late entry. Progress note dated 04/29/24 was created on 05/07/24 as a late entry. 2. Resident #157 was admitted to the facility on [DATE] and discharged to the hospital on 12/15/23, with diagnoses that included Cirrhosis of the Liver and Liver Cancer. Record review revealed Resident #157 was seen by the physician 3 times during the stay at the facility (12/06/23, 12/11/23, and 12/13/23). Further review of Resident #157's physician progress notes revealed: Progress note dated 12/06/23 was created on 04/18/24 as a late entry. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress note dated 12/11/23 was created on 12/29/23 as a late entry. Progress note dated 12/13/23 was created on 12/29/23 as a late entry. An interview was conducted with the Director of Nursing (DON) on 05/08/24 at 11:20 AM. The DON acknowledged the physician's late documentation for Resident #17's and Resident #157's progress notes.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948 Based on observation, interview, and record review, it was determined that the facility failed to prepare pureed foods by methods that conserve nutritive, value, flavor, and appearance for 4 (Residents #5, #7, #19, and #30) of 4 residents with physician ordered Pureed Diet with Pureed Fortified Foods. The findings included: During the observation of the lunch meal in the main kitchen on 05/06/24 at 11:30 AM, foods located on the steam table were observed and were taste tested by the surveyor. Specifically, the Pureed Cheese Ham & Macaroni Casserole, and Pureed Sauteed Spinach noted to be very thin and watery in consistency. The taste test confirmed that the pureed foods were too thin and had a watery consistency. Interview with the Lunch Cook (Staff C) at the time of the observation was noted to state she was unaware that the addition of too much liquid into the pureed food mixture results in decreased nutritional value of the pureed foods, and negative appearance and taste palatability. Staff C stated no state specific training in pureed foods and food are this consistency on a daily basis. It was also noted during the serving that no pureed garnishes were being utilized to increase the pureed foods and/or entree plate appearance. Staff D stated that pureed garnishes have never be used on the pureed entree plates or other pureed foods such as breads and desserts. During the observation of the lunch meal in the main dining room on 05/06/24 residents being served the pureed diet were observed by the surveyor. Observation of Residents #19 and #30 were noted to be seated at the same dining room table. Observation of the main entree plate noted that all pureed foods (Entree, starch, and vegetable) were all running together and beginning to make a slurry from running together. It was also noted that the foods were so watery and thin that they were flowing over the sides of the main entree plate. The surveyor asked LPN (Staff E) who was going to feed the residents what she thought of the pureed foods and stated in front of the 2 residents that she could not eat that mess. The surveyor requested the Corporate Food Service Director (CFSD) to come to the dining room and observe the pureed meals served to Resident #19 and #30. The CFSD stated that the pureed foods were not acceptable due to thin and water consistency, poor nutritive value, and poor appearance and palability. The CFSD failed to replace the pureed meals with acceptable pureed foods for the lunch meal. Further observation of Resident #19 and #30 [NAME] the lunch meal in the dining room noted that Staff E took a spoon and mixed all the foods together into a watery brown consistency and began to feed the two residents. It also noted that Staff E failed to offer the residents some swallows of beverages between food bites. Both residents #19 and #30, stated they could not eat sufficient amounts of the pureed food slurry and consumed less than 25% of the lunch meal. During the lunch meal round conducted on 05/06/24 at 1 PM, Resident #5 was observed by the surveyor and it was noted the same thin watery purred foods. Further noted that Resident #5 was visually impaired and received no assistance from staff during the meal. The resident was was noted to attempt to eat the watery pureed food with her hands and spilled the mixture over her face, body, tray and floor. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the breakfast meal on 05/08/24 at 8:30 AM noted trays served to the room of Resident #19 and #30. Observation of the breakfast pureed foods (pureed scrambled eggs with cheese and biscuit). The pureed food were again noted to be thin, watery, poor appearance, and no pureed garnish. The pureed foods were also noted to be again running into each other on the entree plate. Further observation noted that the breakfast meal tickets also documented a fortified hot cereal. Observation of the hot cereal noted to be a white watery mixture that did not resemble hot cereal. Following the observation the surveyor observed the Pureed Hot Cereal that was being served along with the CFSD. The observation revealed that the hot cereal was thinned out with milk and water. The CFSD stated that the Pureed Fortified Hot Cereal was not acceptable and the recipe would be reviewed with the cook (Staff D). A review of the facility's diet census for 05/06/24 noted that there were currently 4 residents with Physician ordered Pureed Diet which included Residents #5, #7, #19, and #30. Further review of clinical records noted the following: * Review of clinical record of Resident #5 noted: Date Of Admission: 4/23/21 Re-admission: 3/19/24 Diagnoses: Legal Blindness, Post Traumatic Stress Disorder. Gastrostomy Disorder Current Physician orders: 5/7/24 - Osmolyte @75 ml/hr X 20 hours - on at 2 PM - off @10 AM 5/7/24 @ 8 AM - Osmylyte 75 ml/hr running 5/7/24 - Flush water @ 25 ml /hr X 20 hr 4/27/24 = Dysphagia Pureed Diet MDS: 3/24/24 Section B: Understood & Understands Section C: BIMS = 13 (alert & orientated Section D: No Mood Issues Section GG: Eating - Supervision/Assistance Sec J : 67/170# Feeding Tube/Mechanically Altered Diet (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105578	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at the Sea - Harbor Beach	1615 Miami Rd Fort Lauderdale, FL 33316

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Record review of Resident #7 noted the following: Date Of Admission: 7/18/22 Diagnoses: Alzheimer's Disease / Depressive Disorder, Need For Assist with Personal Care, and Cognitive Communication Deficit Current Physician Orders: 7/5/22: Dyspahgia - Pureed - Honey Thick - Large Portions at all meals - 2 PM & HS snack 3/24/23 - Fortified Foods with all meals - pureed MDS : 1/25/24 Section B : Understood & Understands Section C: Rarely /never Understood No BIMS Score = Cognitive Impairment Section D: NO Mood - never understood Section GG: Eat - Dependent On Staff Section K : 66/129# * Review of clinical record of Resident #19 noted: Date Of Admission: 06/1/18 Diagnoses: ASHD, Schizoaffective Disorder, Dysphagia, Cognitive Communication MD Orders: 10/1/21: Pureed /Large Portions entree starch, vegetable, fortified foods with meals 4/23/24 - Med Plus 2.0 -4 oz BID - record % MDS: 3/30/24 - Annual Section C ; 00 - Cognitive Impairment Section D: Rarely/never understood Section GG: Dependent On Staff Section K: NO Swallow Issues/ 65 /110# (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105578	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at the Sea - Harbor Beach	1615 Miami Rd Fort Lauderdale, FL 33316

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Mechanical; Altered Diet * Record Review of Resident #30 noted: Date of Admission: 12/1/22 Diagnoses: Chronic Kidney Disease, Alzheimer's Disease, Depressive Disorder, 10/9/23 - NAS/Dysphagia Pureed. 4/23/24 - Med Pass 2. 0 - 4 oz - QD 10/9/23 - Fortified Foods - Breakfast - hot cereal MDS: 3/28/24 Section C: BIMS=6 (Cognitive Impairment) Section GG: Eating = Dependent on Staff