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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105644 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER Aspire at Fletcher | | STREET ADDRESS, CITY, STATE, ZIP CODE 518 W Fletcher Ave Tampa, FL 33612 | |
| 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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20311</p> <p>Based on record review and interview the facility failed to provide and honor the resident rights for choice related to health insurance for 3 of 3 (#21, #26, #50) residents reviewed for payer source changes.</p> <p>Findings included:</p> <p>1. Review of the facility policy titled Resident Rights with an effective date of 11/30/24 revealed it is the policy of the company to provide on-going training on residents rights to staff members as required by state and/or federal regulations.</p> <p>Interview with the Business Office Manager (BOM) on 07/10/24 at 9:23 AM revealed that if a resident was admitted with straight Medicare their stay would be covered 100% for the first 20 days and at Day 21 the resident will have a deductible unless they have a secondary insurance. She reported that straight Medicare and a Medicare HMO (Health Maintenance Organization) are similar but with the HMO, the facility would have to report to a case manager every week. The BOM reported that when approaching the 20-day mark, the resident was encouraged to disenroll from the Medicare HMO and be placed on straight Medicare based on the residents clinical needs. She reported that the facility does encourage the switch to straight Medicare based on clinical needs; however, residents are not forced to disenroll from their Medicare HMO.</p> <p>2. Review of Resident #21's Census page of his electronic medical record revealed he was admitted to the facility on [DATE] with a primary payer source of MCR LEVEL-[Company Name] Medicare Levels (Medicare HMO). On 6/1/24, the resident's primary payer source was changed to MCA-Medicare A (straight Medicare).</p> <p>Review of the resident's admission Minimum Data Set (MDS) assessment dated [DATE] indicates a Brief Interview For Mental Status (BIMS) score of 13, indicating cognitively intact.</p> <p>Review of the Attestation of Resident or Legal Representative signed 5/29/24 by Resident #21 revealed the resident's signature. Additional review of the form revealed a section on the bottom of the form noting: By signing below, I am attesting that I witnessed the Resident/Legal Representative sign said attestation and in addition to signing the attestation that the Resident/Legal Representative had the opportunities to ask questions and fully understand the document he/she was signing. This section was blank and contained no signature, printed name, or date by the Administrator or Designee.</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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| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 105644 |
| | | If continuation sheet Page 1 of 3 |

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| <p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Interview with Resident #21 on 07/10/24 at 10:48 AM confirmed the signature on 5/29/2024 was his, but he does not remember signing it. He reported that his Old Lady (significant other) told him that he changed his insurance form from a Medicare HMO and wanted to know why. He reported that it did not make sense to change because he had just started the HMO and there was no need to change it. He reported that he does not see the benefit of the new insurance. He stated he was familiar with the HMO and would not have wanted to change from it.</p> <p>During an interview with the BOM on 07/10/24 at 11:58 AM, she reported that the Assistant Business Office Manager (ABOM) communicated to the resident what was on the form and that they sign that they understand. She confirmed that the facility designee date and signature was not completed.</p> <p>3. Review of Resident#26's Census page of the electronic medical record revealed he was admitted to the facility on [DATE] with a payer source of MCR LEVEL-[Company Name] Medicare Levels (Medicare HMO). On 5/1/24, the resident's primary payer source was changed to MCA-Medicare A (straight Medicare).</p> <p>Review of the MDS 5-day assessment dated [DATE] revealed the BIMS could not be completed, and the resident had long and short-term memory problems, no recall of season/location of room/staff names and faces, and had severely impaired cognitive skills for decision making.</p> <p>Review of Resident #26's record revealed a Certificate of Incapacity dated 4/15/24</p> <p>Review of the Attestation of Resident or Legal Representative dated 4/16/24 revealed it had a resident signature dated 4/16/24. Additional review of the form revealed a section on the bottom of the form for the Administrator/Designee's signature, printed name, and date to attest to the resident's signature and that the resident/legal representative had the opportunity to ask questions and fully understood the document he/she was signing. This section was blank.</p> <p>On 07/10/24 at 11:49 AM, the BOM reported she communicated with the resident's ex-wife and informed her about other insurance options, and the ability to disenroll the resident and have him go on straight Medicare. She reported that this was all explained to the ex-wife in Spanish and that she understood the whole process. She reported that she explained to the ex-wife she needed to have the resident sign the disenrollment form. She reported she was not aware the resident was deemed incapacitated the day prior to signing. She confirmed the facility Administrator/designee section was also incomplete.</p> <p>Interview on 07/10/24 at 1:26 PM with the NHA and BOM revealed the resident's ex-wife was aware of the change in insurance and was agreeable to the change. The NHA and BOM reported they felt that the ex-wife signed the form but was unwilling to admit it. The NHA and BOM could not verbalize why the ex-spouse would not have signed her own name and why a facility representative did not witness/sign the attestation portion of the form.</p> <p>4. Review of Resident #50's Census page of his electronic medical record revealed he was admitted to the facility on [DATE] with a primary payer source of MCR LEVEL-[Company Name] (Medicare HMO). On 6/1/24, the resident's primary payer source was changed to MCA-Medicare A (straight Medicare).</p> <p>Review of the resident's admission MDS assessment dated [DATE] revealed a BIMS score of 13, indicating cognitively intact.</p> <p>(continued on next page)</p> | | |

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| <p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the Attestation of Resident or Legal Representative revealed a resident signature dated 5/29/24. Additional review of the bottom of the form revealed the Administrator/Designee's signature, printed name, and date to attest to the resident's signature and that the resident/legal representative had the opportunity to ask questions and fully understood the document he/she was signing was blank.</p> <p>Interview on 07/10/24 at 10:36 AM with Resident #50 confirmed that the signature on the document was his, but when he was initially presented with the form he declined to sign it until he consulted with his sister and then he and his sister spoke to the facility. Resident #50 stated he was told if he stayed on his HMO the insurance would not cover his bills for his stay in the facility, but if he disenrolled and went on straight Medicare it would cover his stay. The resident was told he could change back to the Medicare HMO when he went back to the community.</p> <p>During an interview on 07/10/24 at 11:54 AM with the BOM, she reported speaking to Resident #50. She confirmed the resident initially declined and needed to speak to family before getting back to the BOM. She reported that the BOM and ABOM explained to the resident that he could change back to his previous insurance when he went back into the community. She confirmed the facility's Administrator/Designee signature, printed name, and date to attest to the resident's signature and that the resident/legal representative had the opportunity to ask questions and fully understood the document he/she was signing was blank.</p> | | |