STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105644	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Fletcher	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)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on observation, interview and record review, the facility failed to assess and determine it was safe for a resident to self-administer medications for one (#2) of three sampled residents related to nebulizer treatments. Findings included. During interview and observation on 10/24/2024 at 9:15 a.m., Resident #2 was sitting at the bedside in a wheelchair eating. She was dressed and groomed for the day. Her call light was within reach. Observed a nebulizer with medication in the cup sitting on the resident's bed. She stated she did her own nebulizer treatments. She stated the nurse brought in the medication and put it into the cup. Resident #2 stated when she finished eating, she would do her treatment. She finished eating, placed the mask on her face and turned on the machine. The resident's nurse was not in the room. A staff member walked in and asked the resident if she was alright. Resident #2 answered yes. The staff member exited the room. Resident #2 was admitted on [DATE] and readmitted on [DATE]. Admission record showed diagnoses included but not limited to Cerebral Infarction due to embolism, aphasia, and hypertension. Review of the Minimum Data Set, dated dated dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). Section GG Functional Abilities and Goals showed substantial assistance for toileting and bathing. Review of the physician order dated 4/23/2024, showed Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG (milligram) / 3 ml (milliliter) give 3 ml inhale orally every 8 hours as needed for Shortness of Breath Review of the October 2024 Medication Administration Record (MAR) showed Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG (milligram) / 3 ml (milliliter) give 3 ml inhale orally every 8 hours as needed for Shortness of Breath was administered at 6:18 a.m. and was effective. Review of the Quarterly Data Collection dated 10/08/2024 showed N. Medication Review: 1. Does the resident wish to self-administer medication. No. Review of the care plans showed a lack of self-administration of medication care plan. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105644	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Fletcher	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)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/2024 at 2:20 p.m., the DON (Director of Nursing) stated Resident #2 had not been assessed to perform her own medication administration. The DON stated the process for self-medication included performing an assessment and following-up with the physician. If the physician was okay with the self-medication, an order would be written. They would assess and educate the resident on understanding the times the medications were to be given. It would be care planned. The DON verified Resident #2 did not have a self-administration of medication evaluation or physician orders. Review of the facility's policy, Self-Administration of Medication at Bedside, revised 08/22/2017 showed the resident may request to keep medications at bedside for self-administration in accordance with Resident Rights. Criteria must be met to determine if a resident is both mentally and physically capable of self-administrating medication and to keep accurate documentation of these actions. Procedure: Verify physician's order in the resident's chart for self-administration of specific medications under consideration. Complete Self-administration of Medications Evaluation. The Interdisciplinary Team will review the evaluation and will document Section III. Approval granted must be checked Yes or No. Interdisciplinary team member sign the evaluation section. If approval is not granted, a statement must be written as to reason for denial. Complete the care plan for approved self-administered drugs. Self-administration of meds is reviewed by the Care Plan Team with each quarterly review, and when and change in status is noted. The MAR must identify meds that are self-administered, and the medication nurse will need to follow-up with resident as to documentation and storage of medication during each med pass. If kept at bedside, the medication must be kept in a locked drawer. When a resident is unable to self-administer medications, they will be given by nursing staff until the resident can be reevaluated by the Interdisciplinary Team.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105644	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Fletcher	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)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 34768 Based on observation, interview and record review, the facility failed to follow food menus for two (#4 and #5) of two sampled residents and failed to act upon the grievances of the Resident Council Committee related to food menus. Findings included: During an interview and observation on 10/24/2024 at 9:15 a.m., Resident #5 was sitting in her bed looking at her breakfast in a Styrofoam container. Resident #5 stated she did not get on her tray what was on the menu slip. The slip with her name on it showed Thursday Breakfast 10/24/2024: Double Protein, buttermilk pancakes - 4 each; Margarine - 2 each; Syrup - 2 each; Bacon - 2 slices; Hot Cereal - 6 oz; milk - 8 oz; orange juice - 4 oz; coffee or hot tea-6 oz. Resident #5 stated and on observation she had scrambled eggs, and an untoasted English muffin and oatmeal. Resident #5 stated she got her juice and no milk. She did not get any meat; she was supposed to get bacon. She stated this happened often, what was on the slip was not what she got. Resident #4, Resident #5's roommate, stated she also did not get what was on her menu slip. Her slip with her name on it showed Thursday Breakfast 10/24/2024: Pureed buttermilk pancakes - #8 scp; Margarine - 1 each; Syrup - 1 each; ground sausage patty - #16 scp; Pureed Hot Cereal - #6 scp; milk - 8 oz; orange juice - 4 oz; coffee or hot tea-6 oz; house shake - 1 srv. Resident #4 stated, I ate my eggs. Resident #4 stated she did not get her sausage, she liked sausage. On observation Resident #5 had pureed English muffin and oatmeal. (Photographic evidence) During an interview on 10/24/2024 at 9:45 a.m., the Certified Dietary Manager (CDM) stated he had just arrived and did not know why the menu had been changed. He stated he would have to ask the cook. The cook stated he had to swap the menu with Friday's due to not having enough bacon for today (Thursday). The CDM stated the scrambled eggs today was their protein, they had an English muffin and oatmeal. The CDM stated the bacon would be here on Sunday with the next order. Review of the Week-At-A-Glance showed Thursday the menu for breakfast was Buttermilk pancakes, margarine, syrup and bacon. Friday the menu showed, scrambled eggs, English muffin, margarine and jelly. Review of the Resident Council Minutes dated 09/06/2024 showed food is terrible, no follow up with dietary getting other food besides what is on the ticket. Action taken was blank as well as person responsible. Review of the Resident Council Minutes dated 10/07/2024 showed in Old Business: food is terrible, no follow up with dietary getting other food besides what is on the ticket. During an interview on 10/25/2024 at 3:09 p.m., the Nursing Home Administrator (NHA) stated he spoke with the CDM. The NHA said he would talk to the cook regarding when he (the cook) switched the menu it needed to be communicated to the staff and residents. The NHA stated the education would be provided by the end of next week. He stated he was going to get bacon when the survey was completed (for tomorrow's breakfast). The NHA stated the CDM just told him the bacon did not come in with their Monday order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105644	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Fletcher	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)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/25/2024 at 4:11 p.m., the Traveling Social Worker (SW) verified the complaint of food is terrible and no follow-up with tray getting other food besides what is on the ticket was on the 09/06/2024 Resident Council Minutes. She stated she would go check on the education provided to the dietary staff regarding the concern and follow-up. During an interview on 10/25/2024 at 4:15 p.m. the Traveling SW and the Director of Nursing (DON) stated they were unable to locate any documentation the kitchen staff was educated regarding changing the menus and informing staff, NHA, and the dietician. During an interview on 10/25/2024 at 4:46 p.m., the Dietician stated she expected the kitchen staff to follow the plan. She stated, If they can't follow it they need to create a substitution log and let me know what changes they have planned. I did not get a call this morning. She stated, In the last month they have not informed me of any changes in the menu except for swapping of a vegetable or something. She stated they had not informed her of swapping a whole menu. Observed dietician texting CDM about the changes and the dietician was awaiting a response. The Dietician stated they were to report menu changes to her and the facility. The Dietician, stated, I have had conversations with the CDM about this in the past, to let me know, do not remember when. I know I have said it but will put in writing next time. Review of the facility's policy, Menus, revised 9/2017 showed menus will be planned in advance to meet the nutritional needs of the residents / patients in accordance with established national guidelines. Menus will be developed to meet the criteria through the use of an approved menu planning guide. Procedures: 1. Menu cycles will be developed and tailored to the needs and requirements of the facility. 2. Menus will be periodically presented for resident review, including the resident council, menu review meetings, or other review board as indicated by the center. The menu will identify the primary meal, the alternative meal, and any always offered food and beverage items. 6. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. 7. A menu substitution log will be maintained on file. 8. Menus will be posted in the Dining Services department, dining rooms, and resident/patient care areas. Review of the facility's policy, Resident Council Meeting, dated 11/01/2021 showed residents will be provided the opportunity to meet together at least monthly in an organized group setting to discuss current issues/topics of their choice. Thes topics may include events, activities, resident rights, care as service and concerns. In addition, a review of old business, problem resolution, and development of action plans may be discussed. Procedure: 5. Utilize the Resident Council Minutes - for any issues requiring a follow-up response. Resident Council will review this section each meeting to determine if Concern was resolved, not resolved, or partially resolved. Unresolved or partially resolved concerns are brought forward to the next set of minutes for Resident Council Review. 6. Review Resident Council information at the Quality Assurance Performance Improvement meeting monthly for opportunities for improvement and to address any concerns/grievances. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105644	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Fletcher	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)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, Complaint/Grievance, revised on 10/24/2022 showed the Center will support each resident's right to voice a complaint/grievance without fear of discrimination or reprisal. The center will make prompt efforts to resolve the complaint/ grievance and informed the resident of progress towards resolution. Procedure: 3. The Grievance Officer / designee shall act on the grievance and begin follow up on the concern or submit it to the appropriate department director for follow-up. 4. The grievance follow-up should be completed in a reasonable time frame; this should not exceed 14 days. 8. The individual voicing the grievance will receive a follow-up communication with the resolution .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105644	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Fletcher	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)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 34768 Based on observation, interview and record review, the facility failed to establish and implement a Quality Assurance and Performance Improvement (QAPI) Program that demonstrated identification, monitoring and implementation of an effective action plan to correct citations related to failing to follow food menus for four residents (Resident #4, Resident #14, Resident #15, and Resident #16) of five sampled residents, failing to act upon the grievances of the Resident Council Committee related to food menus, and failing to collaborate with the Registered Dietician related to menu substitutions (F565) during the revisit survey conducted on 12/9/2024. Finding included: Review of the facility's policy titled Quality Assurance and Performance Improvement, revised 10/24/2022, showed the Center and organization has a comprehensive, data-driven Quality Assurance Performance Improvement Program that focuses on indicators of the outcomes of care and quality of care and quality of life. Procedure: Program Design and Scope: 1. The Center's QAPI program is on-going comprehensive review of care and services provided to residents. Including but not limited to e. Dining Services. 2. Important functional areas may include but are not limited to: e. Quality of life. 3. Review of activities may include but not be limited to: c. Resident/family complaints/satisfaction. Leadership: the Center Executive Director is accountable for the overall implementation and functioning of the QAPI program. This includes but is not limited to a) implementation; b) identify priorities; d) ensures performance indicators, resident and staff input and other information is used to prioritize problems and opportunities; e) ensure corrective actions are implemented to address identified problems in systems; f) evaluates the effectiveness of actions. 4. The program is a coordinated effort among departments and services within the organization that involves leadership working with input from Center staff, residents and families. Feedback: the center will obtain feedback to assist in identifying problems and areas of opportunity feedback may be obtained including but not limited to the following sources: c) residents d) resident representatives. 7. The Center may choose multiple processes to obtain feedback, including but not limited to: c. Resident Council. Data Collection System and Monitoring the center will collect and monitor data form different departments reflecting its performance. 8. The center will identify data sources and timeframe for collection. Data sources may include but are not limited to a. grievance logs. Systematic Analysis and Action: the center will ensure systems and actions are in place to improve performance. 11. The center will establish and utilize a systematic approach to identify underlying causes of problems, including but not limited to: a. root cause analysis; b. failure mode effect analysis. 12. The center will develop corrective actions based on the information gathered and review effectiveness of the actions. Identifying Quality Deficiencies and Corrective Action: The center will monitor department performance systems to identify issues or adverse events. 14. The center will review department system data. Performance Improvement Projects: the center utilizes performance improvement projects to improve a systemic problem or improve quality in absence of a problem. Performance Improvement Projects (PIPs) are based on the centers services and resources identified in the Facility Assessment During an interview on 12/9/2024 at 9:25 a.m. Resident #4 stated, it is a hit or miss regarding getting food on the menus. They are doing better. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105644	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Fletcher	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)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/9/2024 at 9:38 a.m. Resident #16 stated, sometimes the meals are a surprise. They will change the dessert or vegetable, not usually the whole plate. During an interview on 12/9/2024 at 10:45 a.m. Resident #14, who was the previous Resident Council President, stated the food was a little bit better. She stated, What is on the ticket is not what they receive all the time. The problem is not completely resolved. She stated on Thanksgiving they had deli turkey instead of real turkey, no mashed potatoes, stuffing, or cranberry sauce. Resident #14 stated Staff G, Kitchen Manager (KM) came last week and spoke to them at the food meeting, for the first time. Resident 14 stated, [Staff G, KM] told us he ordered too late to get real turkey, they were out of the product. Resident #14 stated, Last night we were supposed to get tomato soup, we did not get any soup. During an interview on 12/9/2024 at 11:00 a.m. Resident #16, current Resident Council President, stated they were still having problems with meals. She stated they had Styrofoam plates since yesterday and the food was not warm. Resident #16 stated, They did not give us tomato soup last night even though it was on the menu. I was supposed to get two grilled cheese sandwiches and only got one. It had some type of white cheese not American cheese in it. For Thanksgiving we did not get real turkey, it was deli. We did not get mashed potatoes or stuffing, and I don't remember about the sweet potatoes. I was supposed to get French fries last night and got mashed potatoes instead. I wanted French fries because we always get mashed potatoes. We are still not getting what is on the ticket, not every time. Review of the purchase order dated 11/26/2024 showed condensed cream of mushroom soup out of stock and substituted with cream of potato soup; fancy cut yams out of stock and substituted with 85 count of fresh sweet potatoes; skinless turkey breast (Staff E, District Dietary Manager, verified was deli sliced turkey). Review of the Menu Substitution Log showed: 11/21/2024, dinner, food item substituted was apple crisp; food item omitted was gelatin; RD (Registered Dietician) initials. 11/27/2024, dinner, food item substituted was baked ziti with meat sauce; food item omitted was lasagna; RD initials. 11/28/2024, lunch, food item substituted was Thanksgiving meal; food item omitted was entire lunch menu; RD initials. 11/28/2024, dinner, food item substituted was entire lunch menu; food item omitted was entire dinner menu; RD initials. 12/2/2024, dinner, food item substituted was French fries, food item omitted was tater tots, RD initials. Review of the Week-At-A-Glance menus for 12/8/2024 showed grilled two cheese sandwich, French fries, tomato soup. Review of the purchase order dated 12/4/2024 and 12/6/2024 showed no tomato soup ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105644	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Fletcher	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)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Meal Substitution Daily Audit 12/8/2024 showed breakfast, lunch, and dinner meals matched the daily menu (no mention of lack of tomato soup). Review of the Resident Council Minutes dated 10/7/2024 showed under Old Business, food is terrible, no follow up with dietary getting other food besides what's is on the ticket. Review of the Resident Council Minutes dated 11/5/2024 showed under New or Old Business, nothing regarding food issues or resolution. Review of the Resident Council Minutes dated 12/5/2024 showed under New or Old Business, nothing regarding food issues or resolution Review of a dated 12/4/2024 at 1:30 p.m., yellow lined paper given to surveyor by the Nursing Home Administrator (NHA) on 12/9/2024 at approximately 5:45 p.m. showed, Food Committee will be held once a week on Wed. The kitchen manager came in and spoke a little about the food and what he was going to do different. The yellow lined paper was not signed. Review of the Education In-Service Attendance Record dated 10/31/2024 performed by Staff G, KM showed meeting preferences on tickets are a must, not providing items that the resident requested on the ticket is abuse. Signed by 6 of 13 Dietary staff members. Review of the Education In-Service Attendance Record dated 10/31/2024 performed by Staff G, KM showed missing items are a bit no, nutritional value is compromised, every item is necessary. Signed by 7 of 13 Dietary staff members. Review of the Education In-Service Attendance Record dated 10/31/2024 performed by Staff G, KM showed preferences must be keep and provided to ensure resident satisfaction. Signed by 6 of 13 Dietary staff members. During an interview on 12/9/2024 at 10:50 a.m. Staff G, KM, stated the dish machine was not working as of last night, he had called an outside company, and they were coming this afternoon. They were using Styrofoam plates as of last night. Staff G, KM reviewed the substitution log, and it was not documented as the tomato soup was substituted. The kitchen pantry was observed, and no cans of tomato soup were on the shelves. Staff G, KM stated he did not know why the tomato soup was not served, maybe they (the grocer company) substituted it for the potato soup, they (the grocer company) have been substituting a lot. When asked about the serving of deli turkey instead of a baked turkey, Staff G, KM stated, I have been too busy, I don't remember when I have had a day off, I ordered it late, and they (grocer company) were out of turkey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105644	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Fletcher	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)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/9/2024 at 12:20 p.m. with Staff G, KM and Staff E, Dietary District Manager (DDM) from another area, verified the turkey that was ordered was the deli type not the raw turkey needing to be cooked. Staff E, DDM stated his expectation was to get a raw turkey and cook it for Thanksgiving dinner; cook it and carve it. Staff G, KM was reminded he had told the Resident Council last week they were out of turkey which was why they had deli turkey. Staff E, DDM stated he meant they were out of the ingredients for green bean casserole, not the turkey. Staff G, KM stated ordering the deli turkey was a mis-order. Staff G, KM stated, They have food committee meetings with the Resident Council Meetings. and he had been to the food committee meeting, not that long ago. Staff G, KM stated the food committee meetings used to be monthly but now they are weekly. Staff G, KM stated he does not do any documentation regarding the food committee meetings, and he takes his laptop to the meetings but does not have any documentation. Staff G, KM stated they have had a meeting for the last three months but cannot provide any documentation or sign in sheet. Staff E, DDM stated they do our half (food committee) after the Resident Council Meetings. Staff G, KM stated he had no documentation of participation to verify a food committee meeting. Staff G, KM also stated they ask Resident Council if there are any concerns, but it does not appear there is any documentation that they are concerned. Staff E, DDM stated there was a standard list of questions asked at a food committee meeting. Staff G, KM stated regarding the Plan of Correction for the deficiencies, stated they were to post menus and make sure all the menu items are here. If a substitution was needed, he was to speak with the dietician. Staff G, KM stated again he was not aware of the tomato soup not being served and verified it was not on the substitution log. Staff G, KM stated he was here at lunch (Sunday) but not here for dinner. Staff G, KM stated he thought he checked the menu for Sunday night (for menu items) but must not have. Staff E, DDM and Staff G, KM stated the menu generates a shopper list to order the food from the outside grocer. The shopping list tells you what is needed to make the menu items. Staff E, DDM stated Staff E, KM was to take the shopper list and check the pantry and was to order them whatever items were needed from the outside grocer. They order on Tuesdays and Fridays by 2 p.m. Tuesday orders come in on Wednesdays and Friday orders comes in on Saturdays. Staff E, DDM stated by the end of the day the outside grocer emails Staff G, KM showing substitutions for out-of-stock items. Staff E, DDM also stated it was the responsibility of Staff G, KM to see the email and act accordingly. Staff E, DDM and Staff G, KM verified there was no tomato soup ordered either Tuesday or Friday for Sunday's dinner menu. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105644	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Fletcher	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)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/9/2024 at 12:53 p.m. the facility's Registered Dietician (RD) stated she had educated Staff G, KM on the substitution log. She stated she was at the facility 5 days a week. The RD stated her expectation was to be called prior to the substitution for an okay. The RD also stated, They do not call before. One time they have asked in advance. The RD stated her expectation was if tomato soup was on the menu, to give them (the residents) tomato soup. The RD stated she had not been made aware at the present time regarding the lack of tomato soup with the dinner meal and she was at the facility on Wednesday before Thanksgiving and had not been told of any needs for substitutions. The RD stated Staff G, KM reviewed the Thanksgiving menu with her, of green bean casserole, turkey, pumpkin pie for dessert, sweet potato, and stuffing. The RD stated Staff G, KM reviewed the Thanksgiving menu with her the week before and she expected a cooked turkey versus deli turkey for a Thanksgiving dinner. The RD also stated Staff G, KM told her he was talking to different residents about what they wanted for Thanksgiving. The RD asked Staff G, KM how it (Thanksgiving dinner) went, and he was supposed to show her a picture of the meal but never sent it. The RD verified the green bean casserole was not on the substitution list for Thanksgiving. The RD stated she was planning on going to the Food Committee Meeting on Wednesday and she had not been to any of the Food Committee Meetings but planned to start going weekly. The RD stated, The food could be better. and the purpose of the Food Committee Meetings was to listen to the residents. The RD also stated the residents had been complaining about the grits being dry and hard and she talked to Staff G, KM, who had a new cook to make sure they are looser, so they didn't harden by the time they got to the floor. The RD stated the kitchen staff keeps logs on the food temperature, but she does not monitor them. The RD also stated the food temperature for breakfast was the biggest concern and they have warming plates in the kitchen, but one staff member was not using them. Staff G, KM was told that staff member was not using the warming plates, and to talk to them. The RD stated she did not personally see the education (regarding the use of the warmers) but has seen an improvement. During an interview on 12/9/2024 at 1:46 p.m. with Staff G, KM and Staff F, DDM of the area verified Staff G, KM's picture of the Thanksgiving menu showed yams, a slice of turkey with gravy, green beans, roll and pumpkin pie. Staff F, DDM stated the menu goes to the tracker, the tracker generates the order guide based on the menu, resident diets, and how many meals are needed. Staff F, DDM also stated if they have the food on the shelf and Staff G, KM has three cans of yams and needs six cans of yams, Staff G, KM will order the three cans only. Staff F, DDM stated one truck will deliver for four days and one truck will deliver for three days, and the Friday order would include the Sunday meal. Staff F, DDM stated Staff G, KM should have double checked what was on the shelf and what was needed to be ordered. Staff G, KM stated the expectation was to check the day before for the menu items needed for the next day's meals. Staff G, KM also stated one of the dietary aides puts up the food product and makes sure all the food for the menu was there. Staff G, KM stated the dietary aide verifies on Saturday and the dietary aide would let him know if anything was missing. Staff G, KM stated the missing tomato soup was not told to him until the surveyor brought it up and the dietary aide should have called him to let him know they had no (tomato) soup. Staff G, KM also stated they should have called the dietician, and he had to ask the dietician beforehand for substitutions. Staff G verified gelatin was substituted with apple crisp on 11/21/2024 (switched days of dessert); and French fries was substituted for tater tots on 12/2/2024. Staff E, DDM stated they needed more education, and they needed to use the food report weekly at the Food Committee Meeting. During an interview on 12/9/2024 at 3:30 p.m. the Human Resource Director (HR) provided the job descriptions for Staff G, KM and the Registered Dietician. The HR Director also stated both the employees were contracted employees. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105644	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Fletcher	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)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Clinical Dietician Job Description showed under Responsibilities and Duties: Monitor food service operations to ensure adherence to nutritional standards, sanitation, safety, and quality requirements in accordance with all applicable state and federal regulations. Review of the Dining Services Director/Account Manager Job Description, signed by Staff G, KM on 5/26/2024, showed the Dining Services Director/Account Manager provides leadership, support and guidance to ensure that food quality standards, inventory levels, food safety guidelines and customer service expectations are met and makes sure the facility has sufficient supplies. Training, quality control and in-servicing staff to standards is an essential part of the Manager's responsibility and includes touring kitchen several times per day to assess work quality. Customer Service: responds to customer preferences and industry trends to plan menus; insuring food is prepared by methods that conserve nutritive value, is palatable and attractive to residents, and of a quality that is acceptable to and meets the needs of residents. During an interview on 12/9/2024 at 4:59 p.m. the Nursing Home Administrator (NHA) and the Regional [NAME] President of Operations (RVPO) verified the education provided to the kitchen staff was not 100% of the staff. They stated 6 or 7 staff members educated out of 13 was not acceptable. They stated they expected to see all dietary employees to be documented as to attending the education. They reviewed the Menu Substitution Log and verified the tomato soup substitution for 12/8/2024 was not on the log. They verified there were Menu Substitution Daily Audits performed from 11/15/24 to 12/8/2024 and The Menu Substitution Daily Audit dated 12/8/2024 showed no substitutions, and no documentation of tomato soup. The NHA and the RVPO stated the dietary aide was to check in the supplies, not check the supplies to the menus. The RVPO stated the other facilities were able to obtain the appropriate food for the Thanksgiving meal. The RVPO also stated the prior NHA had educated Staff G, KM and provided a copy of the October 2024 QAPI as education for Staff G, KM. The NHA and the RVPO stated the expectation was for Staff G, KM to be informed about the lack of tomato soup on Sunday (the day of the omission). The NHA and the RVPO stated the expectation was for the menus to be followed unless the RD has approved prior for a substitution. The NHA stated they were going to have a Food Committee Meeting weekly separate from the Resident Council Meeting for the next three or four months and they were going to check the progress bi-weekly. The NHA and RVPO stated they had a QAPI meeting on 11/26/2024 with the current NHA in attendance and found more problems and are addressing them. The RVPO stated, They were going to have to go back and add some things.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105644	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Fletcher	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on observation, interview and record review, the facility failed to follow standard and enhanced barrier precautions when performing urinary catheter care and services for one (#3) of three sampled residents Findings included During an observation on 10/24/2024 at 1:45 p.m., Resident #3 was lying in bed. His urinary catheter bag was lying on the floor. Yellow urine was observed in the bag. No ants noted. During observation and interview with Staff A, Licensed Practical Nurse (LPN) she entered the room and moved the urinary catheter bag from the floor. She attached it to the bed. She entered the bathroom and washed her hands. During an interview, Staff A stated the resident went to the bathroom by himself and must have left the bag on the floor. She stated the catheter bag needed to be off the floor. She reviewed the Enhanced Barrier sign on the door and stated he was on enhanced precautions due to his catheter. Staff A stated she did not put on gloves nor a gown to move his catheter bag. She stated enhanced barrier precautions means to use gowns, gloves and hand sanitize when giving care. She stated she should have put on a gown and gloves to provide care. Resident #3 was admitted on [DATE]. Review of the Admission Record showed diagnoses included but not limited to heart failure, cirrhosis of liver, hypertension, and Benign Prostatic Hyperplasia (BPH). Review of the Medical Certification for Medicaid Long-Term Care Services and Patient Form showed Resident #3 had a urinary catheter that was inserted on 10/18/2024. Review of the physician orders showed change catheter as needed, catheter care every shift, catheter bag to be changed as needed, monitor catheter for patency and drainage every shift, all as of 10/23/2024. Review of the care plans showed Resident #3 had a indwelling catheter, initiated 10/24/2024. Interventions include but not limited to check tubing for kinks each shift. Review of the Admission / Readmission Data Collection dated 10/23/2024 Section K. Genitourinary: Bladder always continent. 2a. Catheter used was blank. 2c. Catheter used, specify type was blank. During an interview on 10/24/2024 at 2:20 p.m., the Director of Nursing (DON) stated Resident #3 was on Enhanced Barrier Precautions due to having a urinary catheter. She stated the nurse should have put on gowns and gloves to touch the bag. The staff was to be fully dressed if doing care. She stated the urinary drainage bag was not to be laid on the floor. She stated that some of the negative outcomes could be an infection issue, pooling of the urine and leaking of urine. She stated the staff was supposed to follow the Enhanced Barrier Precautions with urinary catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105644	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Fletcher	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy, Enhanced Barrier Precautions, dated August 2022 showed Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDRSs) to residents. Policy interpretation and implementation 2. EBP's employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. A. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include g. Device care or use (central line, urinary catheter, feeding tube, tracheostomy / ventilator, etc.). 5. EBP's are indicated when contact precautions do not otherwise apply for residents with wounds and or indwelling medical devices regardless of MDRO colonization. 6. EBP's remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk.