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	12/09/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22481 Based on observation, record review, and interview, the facility failed to implement their Abuse, Neglect, Exploitation, & Misappropriation Policies and Procedures regarding a failure to attempt to verify information from former employers prior to hire for one (Staff A, Certified Nursing Assistant) of four sampled staff members. Findings Included: Review of the facility's Abuse, Neglect, Exploitation, & Misappropriation policies and procedures, Document Name N-1265, effective 11/30/2024, last reviewed 11/16/2022, documented in Policy: It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, polices, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse. Included in the Procedure: 1. Screening: Persons applying for employment with the center will be screened for history of abuse, neglect, exploitation, or misappropriation of resident property. This includes but not limited to: - Employment history. - Criminal background check. - Abuse check with appropriate licensing board and registries, prior to hire. - Sworn disclosure statement prior to hire. - Licensure or registration verification prior to hire. - Documentation of status of any disciplinary actions form (sic) licensing or registration boards and other registries. - Information from former employers. (continued on next page)

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

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The center will ensure that all prospective consultants, contractors, volunteers, caregivers, and students are pre-screened as required by law. A phone interview was conducted on 12/9/2024 at 1:14 p.m. with the Director of Nursing (DON) regarding an allegation of sexual abuse for Resident #8, and Resident #9. The DON stated the Assistant Director of Nursing (ADON) was notified by Staff H, Certified Nursing Assistant (CNA), Resident #8 had stated Staff A, CNA touched his genitals inappropriately and kissed his hands. The police were called. The DON stated Staff A, CNA, was home at the time they learned of the allegation on 11/22/2024 and was suspended. The DON also stated Staff A, CNA worked 3 p.m. to 11 p.m. on 11/21/2024 and it was the next shift where Staff H, CNA became aware of the allegation. The DON stated local police came to the facility interviewed Resident #8. The police turned to ask Resident #9 if he saw anything and that was when Resident #9 said Staff A, CNA, inserted his finger into his rectum for about 10 seconds. The DON said, After that was done, DCF (Department of Children and Families) was notified. They came out and questioned both residents. Both the residents' stories were consistent. I did a quality assurance questionnaire. That was when [Resident #6] said, he slapped my butt when I was getting care. When asked if there was anything that could have been done different, the DON stated, no, we educate on abuse and neglect; we do a great job for education. A review of Resident #6's clinical chart documented an admission on 3/15/2024. Her diagnosis list included but not limited to cerebral infarction due to thrombosis of right middle cerebral artery; need for assistance with personal care and muscle weakness (generalized). A review of Resident #6's Minimum Data Set (MDS) quarterly assessment, dated 9/19/2024, documented under Section C - Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident is cognitively intact. On 12/9/2024 at 9:45 a.m., an observation was conducted of Resident #8, dressed in seasonally appropriate clothing, clean, groomed, self-propelling in wheelchair. He declined to speak about the incident with Staff A, CNA and stated he had told others the information. A review of Resident #8's clinical chart revealed the resident was admitted to the facility on [DATE]. His diagnosis list included but not limited to hemiplegia and hemiparesis following cerebral infarction and muscle weakness (generalized). A review of Resident #8's MDS Quarterly assessment dated [DATE] revealed under Section C - Cognitive Patterns a BIMS score of 15, which indicated the resident is cognitively intact. On 12/9/2024 at 9:50 a.m., an observation was conducted of Resident #9 in bed head watching television and an interview was conducted with the consent of the resident. The resident was hard to understand, paused between sentences, but able to answer questions. When asked if he had been abused or neglected, he stated not since the aid, but did not disclose the particulars of the event. A review of Resident #9's clinical chart revealed he readmitted to the facility on [DATE]. His diagnosis list included but not limited to other sequelae following unspecified cerebrovascular disease and muscle weakness (generalized). (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #9's MDS quarterly assessment, dated 11/2/2024, documented under Section C - Cognitive Patterns, a BIMS score of 11, which indicated Resident #9 has moderate cognitive impairment. An interview was conducted on 12/9/2024 at 11:08 a.m. with the Human Resource Generalist (HRG). When asked if she had a protocol for new hires, she provided an untitled one-page document which included seven sections titled Exhibit X. She stated the form was basically the check list for the employee to be hired. She stated the first two sections were to be completed before the new employee would start. During the interview, a review of the form Exhibit X was conducted and revealed the following in the first section of the document: Signed offer letter Employment Application Resume 1st Reference 2nd Reference Direct Deposit W4 form The HRG stated there should be a first and a second reference documented by the employee on the employment application and/or the Applicant Reference Check form. The HRG also stated, We typically call the reference and ask how the person was as an employee. Review of the Applicant Reference Check form, effective 5/2014, reflected a single page document with the following four sections: Section 1: To be completed by Applicant. Section 2: Reference Responses. Section 3: Telephone Reference only-to be completed by company representative. Section 4: Written Reference-to be completed by reference source. A review of Staff A, CNA's personnel file was conducted. The Level II background screening with an eligibility date of 4/23/2021, print date of 6/07/2024, reflected the employment history of seven providers. Further review of Staff A, CNA's personnel file revealed no documentation of an effort by the hiring facility to verify employment history with any of the providers listed on the Level II Background screening Clearinghouse. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Staff A, CNA's employment application revealed the listing of two private employers. The personnel file reflected no documentation of an effort to verify Staff A, CNA's employment with the two private employers. Further review of Staff A's employment application revealed a box to list three professional references of individuals who are not related to you. The form documented three people's names with the relationship of daughter, wife, and cousin. No documentation was present in the file to indicate an attempt to contact the references. In addition, no other references were listed that were not related to Staff A, CNA. A follow up interview was conducted on 12/9/2024 at 2:18 p.m. with HRG. She was able to show the application for employment Staff A, CNA and confirmed the application listed three relatives of Staff A, CNA as the professional references. She confirmed she did not locate the form to verify the references. No further evidence was provided by the HRG to indicate an attempt to verify employment history or verification of references had been conducted. She confirmed part of the hiring process was to verify references. She said, the form (Exhibit X) was a newer form, but she did not state when the form had been initiated by the facility.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50434 Based on observations, interviews, and record review, the facility failed to ensure treatment and care for management of pain was provided in accordance with professional standards of practice for one resident (Resident #7) of three residents sampled for pain management. Findings included: Review of Resident #7's Admission Record revealed an admitted [DATE] and a readmitted [DATE]. Resident #7 was admitted to the facility with diagnoses of spinal stenosis, morbid severe obesity, chronic pain syndrome, and intervertebral disc disorders, lumbar region. Review of Resident #7's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed under Section H - Health Conditions, Resident #7 was on a scheduled pain medication regimen and received PRN (as needed) pain medications within the five day assessment period. Section H of the Assessment also revealed Resident #7 experienced pain almost constantly, which occasionally affected her sleep and day-to-day activities. Review of Resident #7's physician orders revealed the following orders: - An order dated 3/12/2024 for Percocet (Oxycodone with Acetaminophen) 5 mg (milligrams)-325 mg give one tablet by mouth every eight hours as needed for moderate pain. - An order dated 3/12/2024 for Percocet (Oxycodone with Acetaminophen) 5 mg-325 mg give two tablets by mouth every eight hours as needed for severe pain. An observation on 12/9/2024 at 12:50 p.m., of the [NAME] Side medication cart revealed Resident #7 did not have Percocet 5 mg-325 mg in the medication cart. Further review of the Narcotic Logbook revealed there was not a log for Percocet 5 mg-325 mg. During an interview on 12/9/2024 at 12:40 p.m., Staff I, Registered Nurse (RN), stated if a resident is receiving a narcotic medication, the medication should be in the medication cart and there should be a narcotic log for it. During an interview on 12/9/2024 at 2:49 p.m., Staff K, RN stated generally she gets a count of narcotic medications in the morning, gets a signature, wipes down the cart, look at the census, and starts passing medications. Staff K, RN also stated she looks at the orders and then checks her carts. If a medication has run out, she will reorder the medication from the pharmacy and checks the emergency drug kit (EDK) to see if they have the medication so she can dispense it. She stated she has a few residents who take narcotics, and she checks to see when they were last given to confirm if she can dispense the pain medication. Staff K, RN stated she cross references the narcotics book, documents the administration in the narcotics book, dispenses the medication, and then subtracts one pill from the current count before watching the resident take the medication and documenting the administration in the resident's medication administration record. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/9/2024 at 3:30 p.m., the Assisted Director of Nursing (ADON) stated Resident #7 is seen by pain management and was not able to explain why Resident #7 did not have Percocet in the medication cart. Her expectation would be for the nurses to follow the physician's order and Resident #7 has an order for Percocet, so it should be in the medication cart. During an interview on 12/9/2024 at 4:52 p.m., Staff J, RN, stated Resident #7's Percocet should have been reordered. Staff J, RN also stated Resident #7's pain management team comes to the facility on Tuesday and Thursdays and when she notices a resident is out of pain medication, she texts the physician who will then place the order for more.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50434 Based on observations, interviews, and record review, the facility failed to ensure accuracy of the medical record by failing to document administration of medications for one resident (Resident #7) of three residents sampled for pain management. Findings Included: During an interview on 12/9/2024 at 9:30 a.m., Resident #7 stated she was recently admitted to the hospital because during morning medication pass, her face turned blue. She stated on 11/23/2024, in the morning, she had just removed her oxygen mask when the nurse came into provide her with her medication. Resident #7 stated she took the medication and immediately her face turned blue, and the nurse had to call other staff members into the room. She stated she remembers the Director of Nursing (DON) coming in and calling the physician so they could send her to the emergency room (ER), and she remembers being in an ambulance with Emergency Medical Services (EMS) staff trying to keep her awake. Resident #7 stated when she got to the ER, they took for a CT (computed tomography) scan and the physician came in to see her. She stated she was told by the ER physician that she had overdosed. Review of Resident #7's Admission Record revealed an admitted [DATE] and a readmitted [DATE]. Resident #7 was admitted to the facility with diagnoses of spinal stenosis, morbid severe obesity, anxiety disorder, chronic pain syndrome, and intervertebral disc disorders, lumbar region. Review of Resident #7's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed under Section C - Cognitive Patterns, A Brief Interview for Mental Status (BIMS) score of 15 out of 15, showing Intact cognition. The MDS Assessment also revealed under Section N - Medications, Resident #7 received antidepressant and opioid medications during the assessment period. Review of Resident #7's Order Summary Report, active as of 11/30/2024, revealed the following orders: - An order dated 3/12/2024 for Percocet (Oxycodone with Acetaminophen) 5 mg (milligrams)-325 mg give one tablet by mouth every eight hours as needed for moderate pain. - An order dated 3/12/2024 for Percocet (Oxycodone with Acetaminophen) 5 mg-325 mg give two tablets by mouth every eight hours as needed for severe pain. - An order dated 4/23/2024 for clonazepam 1 mg by mouth every 12 hours for anxiety disorder. - An order dated 11/17/2024 for fentanyl transdermal patch 72 hour 50 mcg (micrograms) per hour, apply one patch transdermally every 72 hours for pain, remove from skin every 3rd day and remove per schedule. - An order dated 4/13/2024 for Naloxone HCl (hydrochloride) injection solution 0.4 mg per mL, inject 1 mL intramuscularly as needed for opioid toxicity. May give an additional 1 mL in 3 minutes if resident is still unresponsive. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/9/2024 at 2:49 p.m., Staff K, RN stated she was assigned to Resident #7 on 11/23/2024 and she was at lunch when she came down the hallway and noticed other staff members in Resident #7's room. She stated the resident was sweaty, and the DON (Director of Nursing), and another nurse were in the resident's room. Staff K, RN stated the DON told her Naloxone HCl was administered to the resident. She stated she was in charge of Resident #7's medication pass that morning and she did not give her any pain medications that day. During an interview on 12/9/2024 at 2:50 p.m., the DON, stated on 11/23/2024 the CNA assigned to Resident #7 came and got her due to Resident #7's face being bright red and lips being blue. She stated when she went into Resident#7's room her oxygen was on, and she was not at her baseline. She called the nurse and the physician, and the physician authorized for her to give Naloxone HCl and Zofran IM (intramuscularly). The DON also took Resident #7's fentanyl patch off, and the resident became more responsive. She stated Resident #7's oxygen level was low, and she administered oxygen via a non-rebreather. The DON stated when EMS arrived, they confirmed the resident's fentanyl patch was off. The DON also stated while Resident #7 was at the hospital, no labs were drawn, but they gave her a diagnosis of an overdose, which she thinks is because Naloxone HCl was administered to the resident prior to going to the hospital. The DON stated the Naloxone HCl administration should be found on the resident's MAR (Medication Administration Record) and there should be documentation of the event from the nurse. Review of Resident #7's Medication Administration Record (MAR), for the month of November 2024 did not show Naloxone HCl was administered. During an interview on 12/9/2024 at 6:00 p.m., Regional of Clinical Services stated if a resident was given Naloxone HCl, she would expect it to be on the resident's MAR. She also stated she was not able to find any documentation regarding Resident #7 needing to be administered Naloxone HCl and being sent to the ER.