STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105718	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Central Park	702 S Kings Ave Brandon, FL 33511

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37999 Based on observations, record review, and interviews, the facility failed to ensure four residents (Resident #5, Resident #6, Resident #7, and Resident #8) of five residents observed requiring assistance with eating, were provided a dignified dining experience. Findings included: On 1/7/25 at 12:50 p.m., an observation showed a staff member standing next to the bed of Resident #5 with utensil in hand. The staff member identified themselves as a speech therapist. On 1/7/25 at 1:02 p.m., an observation showed a covered meal tray sitting on the over-bed table of Resident #8. On 1/7/25 at 1:03 p.m., an observation revealed Staff E, Certified Nursing Assistant (CNA) entered Resident #7's room and stood between the privacy curtain and Resident #7's bed. The observation showed the resident's face was level with the mid-torso of the staff member as Staff E, CNA held a cup with a straw and encouraged the resident to eat. On 1/7/25 at 1:06 p.m., Staff E, CNA left Resident #7's room and was interviewed. Staff E, CNA reported feeding Resident #8 and the resident's roommate at same time. The staff member re-entered the room and sat down on Resident #7's bed, uncovered the meal, and spooned a helping of food into the resident's mouth. On 1/7/25 at 1:11 p.m., an observation revealed a staff member, later identified as Staff F, CNA, standing up between the bed of Resident #6 and the privacy curtain. The staff member placed a spoon with a large amount of food into the resident's mouth. An interview and observation was conducted on 1/7/25 at 1:13 p.m. with Staff G, Registered Nurse (RN). Staff G, RN watched the CNA assisting Resident #6 with eating and stated staff were supposed to stand up while assisting the residents with eating as the previous Director of Nursing said staff were not supposed to sit down. Staff G, RN identified on 1/7/25 at 1:55 p.m. the staff member standing next to Resident #6 was Staff F, CNA. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105718	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2025

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Aspire at Central Park	702 S Kings Ave Brandon, FL 33511

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 1/7/25 at 1:15 p.m. with Staff G, RN and Staff H, CNA. After speaking with Staff H, CNA, Staff G, RN stated staff were supposed to sit down while assisting residents with meals. Staff H, CNA confirmed staff were to sit down while assisting residents with eating. An interview was conducted on 1/7/25 at 4:25 p.m. with the Nursing Home Administrator (NHA). The NHA reported staff were not supposed to stand up while assisting the resident's with eating. The NHA also stated the facility did not have a policy regarding Activities of Daily Living (ADLs) for dependent residents. Review of the policy titled Resident Rights, effective 11/30/2014, revealed under Policy, it is the policy of the company to 1. Make residents and their legal representative aware of residents' rights (and) 2. Ensure that residents' rights are known to staff. The policy also showed under Procedure, ongoing training on resident rights will be given to staff members as required by state and/or federal regulations.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on observation, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for three residents (Resident #2, Resident #3, Resident #4) of three residents sampled for care plans. Findings included: 1. Review of the Admission Record showed Resident #2 was originally admitted to the facility on [DATE]. Resident #2 was readmitted on [DATE] from the hospital and was discharged from the facility to the hospital on 12/31/24. The Admission Record also showed Resident #2 had diagnoses including but not limited to displaced comminuted fracture of shaft of right femur on 12/12/24, Parkinsonism, generalized muscle weakness, Chronic Obstructive Pulmonary Disease, anemia, hypertension, and disorders of bone density. Review of Resident #2's Minimum Data Set (MDS) assessment dated [DATE] showed under Section C - Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #2 was cognitively intact. The Assessment also showed under Section GG - Functional Abilities, Resident #2 was dependent for chair/bed-to-chair transfers. Review of Resident #2's December 2024 physician orders showed the following orders: - Stat x-rays for bilateral knees, hips, and pelvis related to acute pain after fall on 12/8/24. - Send to ER (emergency room) for stat CT (Computed Tomography) of right knee and pelvis related to ground level fall on 12/10/24. - Cleanse buttocks with soap and water, pat dry, apply zinc every shift as of 12/18/24 to 12/20/24. - Cleanse right buttock with wound cleanser, pat dry, apply collagen and dry dressing daily and as needed for soiled or dislodged as of 12/20/24 to 12/27/24. - Wound consult for right calf blister on 12/19/24. - Skin prep to right calf blister every shift for right calf blister as of 12/19/24 to 12/27/24. - Send toER on [DATE]. Review of the Treatment Administration Record (TAR) for December 2024 showed the following: - Cleanse buttocks with soap and water, pat dry, apply zinc every shift as of 12/18/24 to 12/20/24 was performed on 12/18/24 and 12/19/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cleanse right buttock with wound cleanser, pat dry, apply collagen and dry dressing daily and as needed for soiled or dislodged as of 12/20/24 to 12/27/2024 was performed on 12/20/24, 12/21/24, twice on 1/22/24, 12/23/24, 12/24/24, 12/25/24. - Skin prep to right calf blister every shift for right calf blister as of 12/19/2024 to 12/27/2024 was performed on 12/20/24, 12/21, 12/22, 12/23, 12/24, 12/25/24. Review of Resident #2's care plan showed the following: - Resident had an ADL self-care performance deficit related to confusion, dementia, impaired balance, limited mobility and shortness of breath initiated on 06/1/22 and revised on 06/1/22. Interventions included but not limited to skin inspection: required skin inspection daily during care to observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse as of 06/1/22, transfer: required extensive assistance by 2 staff to move between surfaces and as necessary initiated on 06/01/22 and canceled on 12/19/24, and the resident required mechanical lift [brand name] with 2 staff assistance for transfers initiated on 02/16/23 and revised on 12/17/24. - Resident had a displaced comminuted fracture of shaft of right femur related to fall as of 12/20/24. Interventions included but not limited to monitor limb for swelling and skin changes, take pedal pulses (specify frequency) as of 12/20/24, and right knee immobilizer at all times as of 12/20/24. - Resident had potential for impairment of skin integrity related to fragile skin, incontinent, limited mobility; blister right arm resolved, right great ingrown toe nail resolved, red left heel resolved, red heels resolved; initiated 6/1/22 and revised on 8/20/24. Interventions included but not limited to monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to MD (Medical Doctor) as of 6/1/22, and treatment as ordered resolved 2/16/23. Review of Resident #2's Weekly Skin Integrity Review showed the following: - On 12/04/24, skin intact - On 12/18/24, right buttock with two lesions in superior and lower site, clean, no drainage, Unit Manager aware. - On 12/25/24, right lower leg rear with blister; sacrum open area. Review of Resident #2's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (Form 3008) dated 12/22/24 showed skin intact and knee immobilizer on at all times. Review of Resident #2's physician, wound care physician, and nursing progress notes revealed the following: - On 12/8/24 at 11:47 a.m., review of the Situation, Background, Assessment, Recommendation (SBAR) showed right and left knee pain, stat x-ray of both knees and pelvis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 12/8/24 at 3:59 p.m., a nursing progress note showed, reported by a CNA, while transferring resident from the bed to the chair her legs became weak, and resident was lowered to the floor. Resident complained of knee pain, prn (as needed) pain medication was administered. Attending Physician notified, orders noted for stat x-ray of both knees and pelvis. Family member notified of Plan of Care. - On 12/9/24 at 1:32 a.m., a nursing progress note showed the writer called the attending physician to report results for bilateral knee and hip x-ray. Left voice mail requesting a return call to facility. Writer called family, notified of x-ray results, family verbalized understanding. - On 12/9/24 at 6:07 a.m., a nursing progress note showed x-ray results received and reported to APRN (Advanced Practice Registered Nurse). New order received to apply Voltaren gel 1% to bilateral knees 4 times a day for 30 days. - On 12/9/24 at 9:28 a.m., an Interdisciplinary Team (IDT) meeting note showed the IDT met to review a fall that occurred on 12/8/24 at 11:20 a.m. Resident was being transferred and CNA lowered resident to the floor due to knees buckling. Resident has no injury. IDT recommends therapy referral and staff education on transfers. - On 12/10/24 at 1:20 p.m., a physician progress note showed the resident had a non-syncopal ground level fall and was complaining of bilateral knee pain. Ordered x-rays for both knees. No fracture. Came to see her today. She was complaining of right knee pain, and she was unable to move or weight bearing with the right leg. The right knee was very swollen and tender. Will order a stat CT of the knee and pelvis, fracture could be missed in regular x-ray. - On 12/13/24 at 2:26 p.m., a late entry second skin check revealed an open area to the right upper buttock, open area to right lower buttock, and discolorations right lower extremity. - On 12/16/24 at 9:34 a.m., a physician progress note showed resident assumption of care following readmission, right femur fracture. On 12/10/24 the resident presented to the hospital due to a fall at the facility. The resident was found to have bilateral lower extremity deep vein thrombosis and right femur fracture. The resident was evaluated by orthopedics in the hospital and was deemed non-surgical with conservative management. The resident was stabilized and readmitted to the facility. The resident was seen sitting up in bed. The resident appears stable and in no apparent distress. The resident stated she was having 4/10 pain to right lower leg, but the pain was doing much better. - On 12/17/24 at 12:36 p.m., a physician note showed: nurse called due to Resident #2 ground level fall. The resident was complaining of pain. Ordered stat x-ray right knee and pelvis. Visited resident and she was complaining of right knee pain and the knee was very swollen and tender with specific tender point at the level of the post lateral condyle. Considering the possibility of fracture missing in regular x-ray. Resident was sent to the hospital for stat CT of the right femur and pelvis. CT was positive of fracture, acute mildly displaced left posterior condyle. Ultrasound positive for bilateral lower extremities deep vein thrombosis. Resident was evaluated by orthopedic, not a good candidate for surgery considering all her co-morbidities and age. The resident will be sent back to facility after discharge. She was seen today, and she was doing fine. Pain was under control. Family was at bedside. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 12/18/24 at 3:41 p.m., a nursing progress note showed resident was noted with a skin lesion on the lower and superior buttock, measure was 1 cm (centimeter.) Clean. No drainage. Unit Manager was notified, and family was aware. - On 12/19/24, a Wound Assessment Physician progress note showed stage II buttock pressure ulcer, 2.0 x 1.0 x 0.1, present on admission, scant serous drainage. - On 12/19/24, a Physician note showed new blister to the right leg. The nurse called today that resident had blister right leg related to the brace in the leg. Will do wound care and decrease pressure in the area. Resident had right leg brace, skin was normal color and no open area, new blister on right leg, resident status post a fall, right femur fracture and bilateral deep venous thrombosis. - On 12/19/24 at 11:00 a.m., a review of the SBAR showed skin prep every shift to right calf blister. - On 12/19/24 at 4:32 p.m., a nursing progress note showed attending physician ordered wound care for right calf blister and skin prep every shift. - On 12/20/24 at 1:23 p.m., the IDT met to review the skin impairment observed on 12/19/24. Resident had a fluid filled blister to right calf due to right knee immobilizer. IDT recommends to continue current treatment and wrap Right Lower Extremity in ace wrap under immobilizer. - On 12/24/24, a Physician note showed Resident #2 was feeling fine. Pain was in control. Resident stated she was weaker after the fall. Blister on right leg, being followed by wound care in the facility. Resident had right leg brace, skin was normal color and no open area, new blister on right leg, resident status post a fall, right femur fracture and bilateral deep venous thrombosis. - On 12/26/24, a Wound Assessment Physician progress note showed: stage II right anterior buttock pressure injury, 1.0 x 1.0 x 0.1; present on admission, 100% dermis, scant serous drainage. - On 12/26/24, a Physician note showed Resident #2 was complaining of right leg pain, about 7 on the pain scale. Resident family at bedside. Had a long conversation with family, and she stated the resident was in pain. Family thinks brace was hurting her, not helping her. Family wanted resident to be evaluated by orthopedic today. Called the nurse to do orthopedic evaluation today. Resident had right leg brace, skin was normal color and no open area, new blister on right leg, resident status post fall, right femur fracture and bilateral deep venous thrombosis. - On 12/26/24 at 11:15 a.m., a review of the SBAR showed worsening pain, at fracture site, front of right knee; Send to ER. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/7/25 at 2:21 p.m. with the Nursing Home Administrator (NHA), Director of Nursing (DON), Regional Nurse Consultant (RNC), the NHA stated on 12/8/24 at 11:20 a.m., Staff A, CNA did an improper transfer and subsequently had to lower Resident #2 to the floor. The resident was care planned for a sit-to-stand transfer. The NHA stated Staff A, CNA stated she tried to pivot the resident alone and the resident went to the floor on her knees. Staff A, CNA called for help. The NHA stated Staff B, Licensed Practical Nurse (LPN) came in and did an assessment, including vital signs, and skin changes. The resident was complaining of pain in her knees. The attending physician was called and received an order for stat x-rays. The x-rays were negative and the APRN ordered Voltaren 1% and Tylenol. The NHA stated they performed an IDT meeting on 12/9/24 regarding the fall. Staff A, CNA, was educated on transfers on 12/9/24. The NHA read Staff A, CNA's statement, which showed she was transferring her alone and could not hold her weight and lowered the resident to the floor. Staff A, CNA wrote she called for help. The NHA stated Staff A, CNA did not specify why she did the transfer alone. Review of the statement by Staff B, LPN with the NHA showed Staff A, CNA reported while transferring Resident #2 from bed to chair, the residents legs became weak. Lowered to the floor on her knees. Upon examination no visible signs of injury noted. Moving all extremities. Complained of knee pain and medicated with pain meds as needed. Doctor was notified. Order for stat bilateral knee x-ray and pelvis. Family notified of change in condition and Plan of Care. Review of statement by Staff C, LPN with the NHA showed resident on the floor. Observed resident sitting on her knees with legs tucked underneath her. She was sitting on the floor by the bed. Wheelchair was locked between resident and bed. The NHA stated on 12/9/24 at 1:32 a.m., the facility received Resident #2's x-ray results, which were negative and reported them to the physician. The NHA stated on 12/10/24, the attending physician came in and saw the resident. The resident was complaining of pain and received an order for a CT scan and the resident was sent to the hospital for a CT scan on 12/10/24. The NHA stated on 12/12/24, at 12:43 p.m., the hospital sent over a record indicating the resident had a right femoral fracture. The NHA also stated on 12/12/24 at 7:57 p.m., they submitted the report and suspended the CNA during the investigation. The NHA stated on 12/12/24 at 10:10 p.m., the resident returned from the hospital with a soft brace. The NHA also stated on 12/13/24 they started an investigation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA verified a re-admission assessment was not performed when the resident returned to the facility on [DATE]. The NHA verified due to a readmission assessment not being performed, there was not a skin assessment performed. The DON stated a resident in the hospital over 24 hours needed a re-admission assessment. They verified the resident was in the hospital for 48 hours and required a re-admission to the facility. The NHA verified Resident #2's Form 3008 showed the resident's skin was intact. The NHA verified a late entry in the nursing progress notes showing on 12/13/24 at 2:26 p.m., second skin check: open area right upper buttock, open area to right lower buttock, discolorations right lower extremity. The NHA verified A Weekly Skin Integrity Review on 12/18/24, showed right buttock with two lesions in superior and lower site, clean, no drainage, Unit Manager aware. The NHA verified this Weekly Skin Integrity Review was documented six days after Resident #2's re-admission. The NHA verified the resident was seen by the wound care physician on 12/18/24 and wound care was put into place, six days post re-admission. The NHA verified the wound physician note dated 12/19/24 showed the wound was on admission, even though the skin was not assessed upon Resident #2's re-admission. The resident was readmitted on [DATE] with a soft brace in place on the right leg. The DON stated the protocol for the brace was to monitor capillary refill and monitor skin integrity daily. The NHA verified no documentation in the clinical record regarding monitoring the right lower leg and brace fitting was present. The NHA verified the lack of pressure ulcer and/or blister interventions on Resident #2's care plans. The NHA stated she would expect both the buttock pressure ulcer and right lower leg blister to be addressed on the care plans. The NHA verified the care plan related to brace care was not being followed. 2. A review of Resident #3's Admission Record showed Resident #3 was admitted on [DATE] and readmitted on [DATE]. Review of the Admission Record also showed diagnoses including but not limited to cerebral infarction with hemiparesis on the left side, diabetes, spinal stenosis in lumbar region, generalized muscle weakness, and chronic pain syndrome. Review of Resident #3's January 2025 physician orders and Treatment Administration Record (TAR) showed the following: - Cleanse sacrum with soap and water, pat dry and apply zinc daily and as needed as of 10/25/24 to 11/21/24. - Cleanse sacrum with wound cleanser and pat dry, apply collagen and cover with dry dressing daily and as needed as of 11/21/24 to 12/26/24. - Cleanse sacrum with normal saline, pat dry, apply Santyl, and cover with dry dressing as of 12/26/24 to 01/02/25. Review of Resident #3's Wound Physician progress notes showed the following: - On 11/07/24, sacrum wound was resolved. - On 11/21/24, stage III, sacrum wound, 1.5 x 1.0 x 0.2, 100% granulation, light serous drainage. - On 12/5/24, stage III, sacrum wound, 1 x 0.80 x 0.20, 100% granulation, light serous drainage. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 12/12/24, stage III, sacrum wound, 0.80 x 0.50 x 0.20, 70% granulation, 30% slough, light serous drainage, improving. - On 12/18/24, stage III, sacrum wound, 0.50 x 0.50 x 0.20, 100% granulation, light serous drainage, improving. - On 12/26/24, stage III, sacrum wound, 0.50 x 0.50 x 0.20, 100% slough, light serous drainage, improving. Change in wound care to include Santyl. - On 1/2/25, stage III, sacrum wound, 0.50 x 0.30 x 0.20, 60% granulation, 40% slough, light serous drainage, improving. Change in wound care to include collagen. Review of Resident #3's care plans showed the following: - Resident #3 had a pressure injury, left heel, initiated on 9/25/24 and revised 10/18/24. Interventions included but not limited to require pressure relieving/reducing device on bed-chair as of 9/25/24 and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate as of 9/25/24. During an observation on 1/7/25 at 1:55 p.m., Resident #3 was sitting with the head of the bed elevated. No air mattress was observed. During an interview on 1/7/24 at 2:11 p.m., Staff D, CNA entered the room and confirmed by pushing on the bed the resident did not have an air mattress. During an interview on 1/7/25 at 2:21 p.m. with the Nursing Home Administrator (NHA), Director of Nursing (DON), Regional Nurse Consultant (RNC), the NHA verified the sacrum pressure ulcer was not addressed on Resident #3's care plans and the expectation was for the sacrum pressure ulcer to be on the care plan, including interventions. The NHA and DON stated once a pressure wound has reached stage III or higher or if the wound care physician requested, an air mattress would be ordered. The NHA stated Resident #3 should be on an air mattress. 3. A review of Resident #4's Admission Record showed Resident #4 was admitted on [DATE]. Review of the Admission Record also showed diagnoses including but not limited to cutaneous abscess of buttock, Cerebral infarction, generalized muscle weakness, metabolic encephalopathy, traumatic subdural hemorrhage, dementia, underweight, Altered Mental Status, pleural effusion, anemia, and hypertension. Review of Resident #4's Baseline Care Plan and Summary dated 1/2/25 showed the following: - Altered Skin Integrity/Potential for showed goals as prevent any skin breakdown or injury and heal/improve current skin issue. Interventions: follow facility skin protocol, turn every 2 hours and as needed, immediately report any skin redness to nurse; report an y skin breakdown to charge nurse, provide incontinent care as needed. - Self-Care Deficit - ADL - Function Rehab Potential was blank for interventions. - Infection: blank. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's care plans showed the following: - On IV antibiotic medications related to gluteal abscess as of 1/2/25. Interventions related to IV site only. Review of Resident #4's January 2025 physician orders and TAR for January 2025 showed the following: - Cleanse sacrum with wound cleanser, pat dry, apply collagen and dry dressing every day as of 1/2/25. - Cleanse sacrum wounds with normal saline and pat dry, apply Santyl and cover with super absorbent dressing daily and as needed as of 1/3/25. - Isolation type, enhanced barriers for wounds, Foley and midline as of 1/7/25. - Cefepime HCl (hydrochloride) IV (Intravenous) 1 gm (gram) every 12 hours for abscess of buttocks as of 1/1/25 to 1/10/25. - Micafungin Sodium IV 100 mg (milligrams) in the a.m. for abscess of buttocks as of 1/1/25 to 1/10/25. Review of a Wound Physician note dated 1/2/25 showed Resident #4 had a stage IV pressure injury of the sacrum back, 5 cm x 4 cm x 0.1 cm, 40% granulation and 60% slough, macerated peri-wound, moderate serous drainage. Review of a physician progress note dated 1/3/25 showed Resident #4 primary diagnosis of dementia. The resident presented to the hospital due to Altered Mental Status. Resident found to have right buttock abscess. Resident had an incision and drainage of wound and was placed on antibiotics. An observation on 1/7/25 at 1:59 p.m. showed Resident #4 was lying on an air mattress with an air pump in place. During an interview on 1/7/25 at 2:21 p.m. with the NHA, DON, and RNC, the NHA verified Resident #4's Baseline Care Plan lacked documentation related to the stage IV sacrum pressure wound, IV antibiotics for infected sacrum pressure wound, and did not have interventions for transfers. The NHA stated the expectation was for the Baseline Care Plan to be completed on admission. The DON stated she was not sure if the Infection Control Preventionist had revised the resident for appropriate antibiotics and isolation precautions. Review of the facility's policy titled Plans of Care, revised 9/25/17 showed an individualized person-centered plan of care will be established by the IDT with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. Plan of Care is to be maintained as part of the final medical record. The policy also revealed the following Procedure: (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. - Develop and implement an individualized Person-Centered baseline plan of care within 48 hours of admission that includes, but not limited to, initial goals based on the admission orders, physician orders, dietary orders, therapy services, social services, PASARR (Preadmission Screening and Resident Review) recommendations, if applicable, and other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs are met appropriately until the Comprehensive plan of care is completed. - Review, update and / or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each OBRA (Omnibus Budget Reconciliation Act) MDS assessment, and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental, and psychosocial well-being. - The individualized Person-Centered plan of care may include but is not limited to the following: services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required by state and federal regulatory requirements.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on observation, interviews, and record review, the facility failed to ensure residents received necessary treatment and services consistent with profession standards of practice related to pressure wounds/ ulcers for two residents (Resident #2 and Resident #3) of three residents sampled for pressure wounds/ ulcers. Findings included: 1. Review of the Admission Record showed Resident #2 was originally admitted to the facility on [DATE]. Resident #2 was readmitted on [DATE] from the hospital and was discharged from the facility to the hospital on 12/31/24. The Admission Record also showed Resident #2 had diagnoses including but not limited to displaced comminuted fracture of shaft of right femur on 12/12/24, Parkinsonism, generalized muscle weakness, Chronic Obstructive Pulmonary Disease, anemia, hypertension, and disorders of bone density. Review of Resident #2's Minimum Data Set (MDS) assessment dated [DATE] showed under Section C - Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #2 was cognitively intact. The Assessment also showed under Section GG - Functional Abilities, Resident #2 was dependent for chair/bed-to-chair transfers. Review of Resident #2's December 2024 physician orders showed the following orders: - Stat x-rays for bilateral knees, hips, and pelvis related to acute pain after fall on 12/8/24. - Send to ER (emergency room) for stat CT (Computed Tomography) of right knee and pelvis related to ground level fall on 12/10/24. - Cleanse buttocks with soap and water, pat dry, apply zinc every shift as of 12/18/24 to 12/20/24. - Cleanse right buttock with wound cleanser, pat dry, apply collagen and dry dressing daily and as needed for soiled or dislodged as of 12/20/24 to 12/27/24. - Wound consult for right calf blister on 12/19/24. - Skin prep to right calf blister every shift for right calf blister as of 12/19/24 to 12/27/24. - Send toER on [DATE]. Review of the Treatment Administration Record (TAR) for December 2024 showed the following: - Cleanse buttocks with soap and water, pat dry, apply zinc every shift as of 12/18/24 to 12/20/24 was performed on 12/18/24 and 12/19/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cleanse right buttock with wound cleanser, pat dry, apply collagen and dry dressing daily and as needed for soiled or dislodged as of 12/20/24 to 12/27/2024 was performed on 12/20/24, 12/21/24, twice on 1/22/24, 12/23/24, 12/24/24, 12/25/24. - Skin prep to right calf blister every shift for right calf blister as of 12/19/2024 to 12/27/2024 was performed on 12/20/24, 12/21, 12/22, 12/23, 12/24, 12/25/24. Review of Resident #2's Weekly Skin Integrity Review showed the following: - On 12/04/24, skin intact - On 12/18/24, right buttock with two lesions in superior and lower site, clean, no drainage, Unit Manager aware. - On 12/25/24, right lower leg rear with blister; sacrum open area. Review of Resident #2's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (Form 3008) dated 12/22/24 showed skin intact and knee immobilizer on at all times. Review of Resident #2's physician, wound care physician, and nursing progress notes revealed the following: - On 12/8/24 at 11:47 a.m., review of the Situation, Background, Assessment, Recommendation (SBAR) showed right and left knee pain, stat x-ray of both knees and pelvis. - On 12/8/24 at 3:59 p.m., a nursing progress note showed, reported by a CNA, while transferring resident from the bed to the chair her legs became weak, and resident was lowered to the floor. Resident complained of knee pain, prn (as needed) pain medication was administered. Attending Physician notified, orders noted for stat x-ray of both knees and pelvis. Family member notified of Plan of Care. - On 12/9/24 at 1:32 a.m., a nursing progress note showed the writer called the attending physician to report results for bilateral knee and hip x-ray. Left voice mail requesting a return call to facility. Writer called family, notified of x-ray results, family verbalized understanding. - On 12/9/24 at 6:07 a.m., a nursing progress note showed x-ray results received and reported to APRN (Advanced Practice Registered Nurse). New order received to apply Voltaren gel 1% to bilateral knees 4 times a day for 30 days. - On 12/9/24 at 9:28 a.m., an Interdisciplinary Team (IDT) meeting note showed the IDT met to review a fall that occurred on 12/8/24 at 11:20 a.m. Resident was being transferred and CNA lowered resident to the floor due to knees buckling. Resident has no injury. IDT recommends therapy referral and staff education on transfers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 12/10/24 at 1:20 p.m., a physician progress note showed the resident had a non-syncopal ground level fall and was complaining of bilateral knee pain. Ordered x-rays for both knees. No fracture. Came to see her today. She was complaining of right knee pain, and she was unable to move or weight bearing with the right leg. The right knee was very swollen and tender. Will order a stat CT of the knee and pelvis, fracture could be missed in regular x-ray. - On 12/13/24 at 2:26 p.m., a late entry second skin check revealed an open area to the right upper buttock, open area to right lower buttock, and discolorations right lower extremity. - On 12/16/24 at 9:34 a.m., a physician progress note showed resident assumption of care following readmission, right femur fracture. On 12/10/24 the resident presented to the hospital due to a fall at the facility. The resident was found to have bilateral lower extremity deep vein thrombosis and right femur fracture. The resident was evaluated by orthopedics in the hospital and was deemed non-surgical with conservative management. The resident was stabilized and readmitted to the facility. The resident was seen sitting up in bed. The resident appears stable and in no apparent distress. The resident stated she was having 4/10 pain to right lower leg, but the pain was doing much better. - On 12/17/24 at 12:36 p.m., a physician note showed: nurse called due to Resident #2 ground level fall. The resident was complaining of pain. Ordered stat x-ray right knee and pelvis. Visited resident and she was complaining of right knee pain and the knee was very swollen and tender with specific tender point at the level of the post lateral condyle. Considering the possibility of fracture missing in regular x-ray. Resident was sent to the hospital for stat CT of the right femur and pelvis. CT was positive of fracture, acute mildly displaced left posterior condyle. Ultrasound positive for bilateral lower extremities deep vein thrombosis. Resident was evaluated by orthopedic, not a good candidate for surgery considering all her co-morbidities and age. The resident will be sent back to facility after discharge. She was seen today, and she was doing fine. Pain was under control. Family was at bedside. - On 12/18/24 at 3:41 p.m., a nursing progress note showed resident was noted with a skin lesion on the lower and superior buttock, measure was 1 cm (centimeter.) Clean. No drainage. Unit Manager was notified, and family was aware. - On 12/19/24, a Wound Assessment Physician progress note showed stage II buttock pressure ulcer, 2.0 x 1.0 x 0.1, present on admission, scant serous drainage. - On 12/19/24, a Physician note showed new blister to the right leg. The nurse called today that resident had blister right leg related to the brace in the leg. Will do wound care and decrease pressure in the area. Resident had right leg brace, skin was normal color and no open area, new blister on right leg, resident status post a fall, right femur fracture and bilateral deep venous thrombosis. - On 12/19/24 at 11:00 a.m., a review of the SBAR showed skin prep every shift to right calf blister. - On 12/19/24 at 4:32 p.m., a nursing progress note showed attending physician ordered wound care for right calf blister and skin prep every shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 12/20/24 at 1:23 p.m., the IDT met to review the skin impairment observed on 12/19/24. Resident had a fluid filled blister to right calf due to right knee immobilizer. IDT recommends to continue current treatment and wrap Right Lower Extremity in ace wrap under immobilizer. - On 12/24/24, a Physician note showed Resident #2 was feeling fine. Pain was in control. Resident stated she was weaker after the fall. Blister on right leg, being followed by wound care in the facility. Resident had right leg brace, skin was normal color and no open area, new blister on right leg, resident status post a fall, right femur fracture and bilateral deep venous thrombosis. - On 12/26/24, a Wound Assessment Physician progress note showed: stage II right anterior buttock pressure injury, 1.0 x 1.0 x 0.1; present on admission, 100% dermis, scant serous drainage. - On 12/26/24, a Physician note showed Resident #2 was complaining of right leg pain, about 7 on the pain scale. Resident family at bedside. Had a long conversation with family, and she stated the resident was in pain. Family thinks brace was hurting her, not helping her. Family wanted resident to be evaluated by orthopedic today. Called the nurse to do orthopedic evaluation today. Resident had right leg brace, skin was normal color and no open area, new blister on right leg, resident status post fall, right femur fracture and bilateral deep venous thrombosis. - On 12/26/24 at 11:15 a.m., a review of the SBAR showed worsening pain, at fracture site, front of right knee; Send to ER. Review of Resident #2's care plan showed the following: - Resident had an ADL self-care performance deficit related to confusion, dementia, impaired balance, limited mobility and shortness of breath initiated on 06/1/22 and revised on 06/1/22. Interventions included but not limited to skin inspection: required skin inspection daily during care to observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse as of 06/1/22, transfer: required extensive assistance by 2 staff to move between surfaces and as necessary initiated on 06/01/22 and canceled on 12/19/24, and the resident required mechanical lift [brand name] with 2 staff assistance for transfers initiated on 02/16/23 and revised on 12/17/24. - Resident had a displaced comminuted fracture of shaft of right femur related to fall as of 12/20/24. Interventions included but not limited to monitor limb for swelling and skin changes, take pedal pulses (specify frequency) as of 12/20/24, and right knee immobilizer at all times as of 12/20/24. - Resident had potential for impairment of skin integrity related to fragile skin, incontinent, limited mobility; blister right arm resolved, right great ingrown toe nail resolved, red left heel resolved, red heels resolved; initiated 6/1/22 and revised on 8/20/24. Interventions included but not limited to monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to MD (Medical Doctor) as of 6/1/22, and treatment as ordered resolved 2/16/23. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/7/25 at 2:21 p.m. with the Nursing Home Administrator (NHA), Director of Nursing (DON), Regional Nurse Consultant (RNC), the NHA stated on 12/8/24 at 11:20 a.m., Staff A, CNA did an improper transfer and subsequently had to lower Resident #2 to the floor. The resident was care planned for a sit-to-stand transfer. The NHA stated Staff A, CNA stated she tried to pivot the resident alone and the resident went to the floor on her knees. Staff A, CNA called for help. The NHA stated Staff B, Licensed Practical Nurse (LPN) came in and did an assessment, including vital signs, and skin changes. The resident was complaining of pain in her knees. The attending physician was called and received an order for stat x-rays. The x-rays were negative and the APRN ordered Voltaren 1% and Tylenol. The NHA stated they performed an IDT meeting on 12/9/24 regarding the fall. Staff A, CNA, was educated on transfers on 12/9/24. The NHA read Staff A, CNA's statement, which showed she was transferring her alone and could not hold her weight and lowered the resident to the floor. Staff A, CNA wrote she called for help. The NHA stated Staff A, CNA did not specify why she did the transfer alone. Review of the statement by Staff B, LPN with the NHA showed Staff A, CNA reported while transferring Resident #2 from bed to chair, the residents legs became weak. Lowered to the floor on her knees. Upon examination no visible signs of injury noted. Moving all extremities. Complained of knee pain and medicated with pain meds as needed. Doctor was notified. Order for stat bilateral knee x-ray and pelvis. Family notified of change in condition and Plan of Care. Review of statement by Staff C, LPN with the NHA showed resident on the floor. Observed resident sitting on her knees with legs tucked underneath her. She was sitting on the floor by the bed. Wheelchair was locked between resident and bed. The NHA stated on 12/9/24 at 1:32 a.m., the facility received Resident #2's x-ray results, which were negative and reported them to the physician. The NHA stated on 12/10/24, the attending physician came in and saw the resident. The resident was complaining of pain and received an order for a CT scan and the resident was sent to the hospital for a CT scan on 12/10/24. The NHA stated on 12/12/24, at 12:43 p.m., the hospital sent over a record indicating the resident had a right femoral fracture. The NHA also stated on 12/12/24 at 7:57 p.m., they submitted the report and suspended the CNA during the investigation. The NHA stated on 12/12/24 at 10:10 p.m., the resident returned from the hospital with a soft brace. The NHA also stated on 12/13/24 they started an investigation. (continued on next page)

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

The NHA verified a re-admission assessment was not performed when the resident returned to the facility on [DATE]. The NHA verified due to a readmission assessment not being performed, there was not a skin assessment performed. The DON stated a resident in the hospital over 24 hours needed a re-admission assessment. They verified the resident was in the hospital for 48 hours and required a re-admission to the facility. The NHA verified Resident #2's Form 3008 showed the resident's skin was intact. The NHA verified a late entry in the nursing progress notes showing on 12/13/24 at 2:26 p.m., second skin check: open area right upper buttock, open area to right lower buttock, discolorations right lower extremity. The NHA verified A Weekly Skin Integrity Review on 12/18/24, showed right buttock with two lesions in superior and lower site, clean, no drainage, Unit Manager aware. The NHA verified this Weekly Skin Integrity Review was documented six days after Resident #2's re-admission. The NHA verified the resident was seen by the wound care physician on 12/18/24 and wound care was put into place, six days post re-admission. The NHA verified the wound physician note dated 12/19/24 showed the wound was on admission, even though the skin was not assessed upon Resident #2's re-admission. The resident was readmitted on [DATE] with a soft brace in place on the right leg. The DON stated the protocol for the brace was to monitor capillary refill and monitor skin integrity daily. The NHA verified no documentation in the clinical record regarding monitoring the right lower leg and brace fitting was present. The NHA verified the lack of pressure ulcer and/or blister interventions on Resident #2's care plans. The NHA stated she would expect both the buttock pressure ulcer and right lower leg blister to be addressed on the care plans. The NHA verified the care plan related to brace care was not being followed.

2.

A review of Resident #3's Admission Record showed Resident #3 was admitted on [DATE] and readmitted on [DATE]. Review of the Admission Record also showed diagnoses including but not limited to cerebral infarction with hemiparesis on the left side, diabetes, spinal stenosis in lumbar region, generalized muscle weakness, and chronic pain syndrome.

Review of Resident #3's January 2025 physician orders and Treatment Administration Record (TAR) showed the following:

- Cleanse sacrum with soap and water, pat dry and apply zinc daily and as needed as of 10/25/24 to 11/21/24.

- Cleanse sacrum with wound cleanser and pat dry, apply collagen and cover with dry dressing daily and as needed as of 11/21/24 to 12/26/24.

- Cleanse sacrum with normal saline, pat dry, apply Santyl, and cover with dry dressing as of 12/26/24 to 01/02/25.

Review of Resident #3's Wound Physician progress notes showed the following:

- On 11/07/24, sacrum wound was resolved.

- On 11/21/24, stage III, sacrum wound, 1.5 x 1.0 x 0.2, 100% granulation, light serous drainage.

- On 12/5/24, stage III, sacrum wound, 1 x 0.80 x 0.20, 100% granulation, light serous drainage.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 12/12/24, stage III, sacrum wound, 0.80 x 0.50 x 0.20, 70% granulation, 30% slough, light serous drainage, improving. - On 12/18/24, stage III, sacrum wound, 0.50 x 0.50 x 0.20, 100% granulation, light serous drainage, improving. - On 12/26/24, stage III, sacrum wound, 0.50 x 0.50 x 0.20, 100% slough, light serous drainage, improving. Change in wound care to include Santyl. - On 1/2/25, stage III, sacrum wound, 0.50 x 0.30 x 0.20, 60% granulation, 40% slough, light serous drainage, improving. Change in wound care to include collagen. Review of Resident #3's care plans showed the following: - Resident #3 had a pressure injury, left heel, initiated on 9/25/24 and revised 10/18/24. Interventions included but not limited to require pressure relieving/reducing device on bed-chair as of 9/25/24 and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate as of 9/25/24. During an observation on 1/7/25 at 1:55 p.m., Resident #3 was sitting with the head of the bed elevated. No air mattress was observed. During an interview on 1/7/24 at 2:11 p.m., Staff D, CNA entered the room and confirmed by pushing on the bed the resident did not have an air mattress. During an interview on 1/7/25 at 2:21 p.m. with the Nursing Home Administrator (NHA), Director of Nursing (DON), Regional Nurse Consultant (RNC), the NHA verified the sacrum pressure ulcer was not addressed on Resident #3's care plans and the expectation was for the sacrum pressure ulcer to be on the care plan, including interventions. The NHA and DON stated once a pressure wound has reached stage III or higher or if the wound care physician requested, an air mattress would be ordered. The NHA stated Resident #3 should be on an air mattress. Review of the facility's policy titled Clinical Guideline Skin and Wound dated 4/1/17 showed an Overview to provide a system for identifying skin at risk, implementing individual interventions, including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of prevention of pressure injury. The policy also revealed the following Process: - On admission/re-admission the resident's skin will be evaluated for baseline skin condition and documented in the medical record - Licensed Nurse to complete skin evaluation weekly and prior to transfer / discharge and document in the medical record - CNA to complete skin observations and report changes to Licensed Nurse - Licensed Nurse to document presence of skin impairment/new skin impairment when observed and weekly until resolved - Licensed Nurse to report changes in skin integrity to the physician/practitioner and resident / responsible party and document in the medical record (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Develop individualized goals and interventions and document on the care plan and the CNA Kardex - Monitor residents' response to treatment and modify treatment as indicated - Evaluate the effectiveness of interventions, and progress towards goals during the care management meeting and as needed.