

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Aspire at the Gardens - Tallahassee		STREET ADDRESS, CITY, STATE, ZIP CODE 1650 Phillips Rd Tallahassee, FL 32308	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>48580</p> <p>Based on observation, resident and staff interviews, and record review, the facility failed to develop a comprehensive person-centered care plan to maintain the resident's highest practicable level of physical functioning for 1 of 28 sampled residents. (Resident #88)</p> <p>The findings include:</p> <p>On 02/10/25 at 01:56 PM during an interview with Resident # 88, the resident was asked if they are ever gotten out of bed. The resident replied that their wheelchair is too large and they cannot maneuver it because of the size. She stated she cannot sit up straight due to right-sided weakness and because it is very painful. The resident stated that they have not gotten out of bed but would like to if they had a more comfortable wheelchair. Resident #88 states that they have told staff but nothing has been done.</p> <p>On 02/12/25 at 12:10 PM, an interview was conducted with Staff H (Unit Manager for the 100, 200, and 300 halls). She stated she is new to the position since December and is still learning her role and that she was unaware of any requested equipment needs. She stated that this resident does refuse to get out of bed but could not identify any documentation of refusal and had no answer as to why the resident might be refusing.</p> <p>A review of medical record reveals an order dated 5/25/2024 stating May have restorative/maintenance programs as indicated.</p> <p>The discharge notes from therapy services indicated that the resident had received services from 5/27/2024 to 7/18/2024. The resident was discharged from therapy at that time due to achieving maximum potential. There was recommendations for a Restorative Splint and Brace program with splint to Left Upper Extremity (LUE) and Left lower extremity (LLE) knee for contracture prevention and Bed Mobility Program. Prognosis was noted as Good with consistent staff follow-through.</p> <p>A review of the Care Plan for Resident #88 reveals that she is care planned for an Alteration in Usual Functional Performance in Mobility/Transfer status related to weakness, impaired mobility, balance and gait with reference to Independent resident performance of wheelchair use in room and hall. However, there is no care plan referencing Restorative Nursing or Splint and Brace Program recommended for prevention of contractures.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>48580</p> <p>Based on observation, staff interviews, and record review, the facility failed to provide equipment and restorative services to prevent a further decrease in range of motion for 1 of 3 residents sampled for limited range of motion. (Resident #88).</p> <p>The findings include:</p> <p>On 02/10/25 at 02:47 PM, Resident #88 was observed to have contractures of the left arm/wrist/hand. No supportive devices were noted in the room.</p> <p>On 02/11/25 at 02:10 PM, Resident #88 was observed to be receiving personal care in bed from the nursing aide. Resident #88's left arm and leg were noted to be severely contracted, affecting the resident's ability to change positions.</p> <p>On 02/12/25 at 09:45 AM, the Director of Physical Therapy stated that he has not received any requests for equipment needs for this resident. He verified that, unless consulted, a resident that is not receiving therapy services would not be evaluated for equipment needs.</p> <p>On 02/12/25 at 11:55 AM, an interview was conducted with Staff G, a Licensed Practical Nurse (LPN). She confirmed that equipment needs are provided through PT/OT but the nurse has to let them know if the resident is not receiving therapy.</p> <p>On 02/13/25 at 10:25 AM, a second interview was conducted with the Director of Therapy services regarding Resident #88's current mobility status. He stated that since the resident was not currently receiving services. He confirmed that he had not received any requests for re-evaluation of this resident until this morning. He stated that he was not aware of the extent of resident's contractures as he had not assessed them yesterday. No orders for therapy have been written. He concurred that the resident's condition may have deteriorated due to lack of staffing and a breakdown in communication between Nursing Services and Therapy.</p> <p>On 02/13/2025 at approximately 12:00 PM, Resident #88 verified that she has never been offered, received, or refused splints for her wrist or legs.</p> <p>In reviewing Resident #88's medical record, orders were noted on admitted d 5/25/2024 for physical therapy to eval and treat as indicated. Rehab potential was defined as Good.</p> <p>In reviewing the discharge notes from Therapy Services, the notes indicated that the resident had received services from 5/27/2024 to 7/18/2024. The resident was discharged from therapy at that time due to achieving maximum potential with recommendations for Restorative Splint and Brace program with splint to Left Upper Extremity (LUE) and Left lower extremity (LLE) knee for contracture prevention and Bed Mobility Program. Prognosis was noted as Good with consistent staff follow-through.</p> <p>Review of Medication / Task Administration records reveals no order or task identified for Restorative services or to apply wrist/leg splints.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951</p> <p>Based on observation, interview, and policy review, the facility failed to provide appropriate urinary catheter care for 1 of 1 resident reviewed for catheter care. (Resident #97)</p> <p>The findings included:</p> <p>During a tour of the facility conducted on 02/10/25 at 12:50 PM, Resident #97 was noted with a urinary catheter. When asked how often the staff clean his catheter, Resident #97 stated the staff did not clean his catheter regularly.</p> <p>A review of Resident #97's medical record revealed he was initially admitted to the facility on [DATE] and was last readmitted on [DATE]. Resident #97 had a medical history significant for Paraplegia, Hematuria, and Urinary Tract Infections. A review of Resident #97's Admission Minimum Data Set (MDS), dated [DATE], revealed he had a Brief Interview of Mental Status Score of 11, which indicates he had moderate cognitive impairment. This MDS documented the presence of the urinary catheter. Resident #97's physician orders revealed there were orders written on 01/11/25 regarding Catheter care every shift and as needed.</p> <p>An interview was conducted with Staff A, a Certified Nursing Assistant (CNA), on 02/13/25 at 9:30 AM. Staff A was assigned to care for Resident #97 that day. When asked about Staff A performing catheter and perineal care on Resident #97, Staff A stated she was unaware of how to perform catheter care. Staff A further stated she did not typically work on Resident #97's hallway. When asked if she had cared for other residents with catheters on the other hallways at the facility, Staff A she stated she had.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A urinary catheter care observation was conducted with Staff A, CNA and Staff B, CNA on 02/13/25 at 10:33 AM. They gathered towels, washcloths, disposable chux, and an incontinence brief. Staff A and Staff B washed their hands and donned gloves. Staff A had a handful of gloves in her scrub top pocket that she used throughout the catheter care observation. Staff A filled two bath basins with warm water in Resident #97's bathroom while Staff B removed Resident #97's sheets and incontinence brief. Staff A washed her hands and donned a new pair of gloves from her pocket prior to beginning the catheter care. At Staff B's recommendation, Staff A picked the catheter bag up off the bed frame and, raising it above the level of the bladder, moved it onto the bed. There was no catheter securement device present. Staff A placed multiple washcloths in both bath basins and a bar of soap in one bath basin. Staff A then removed a washcloth from the water bin containing the bar of soap, applied soap onto the washcloth, and proceeded to clean Resident #97's penis, from the head back up the shaft. Staff A then verbalized she did not know how to pull back Resident #97's foreskin, so Staff B assisted her in this task, revealing Resident #97's glans penis. The glans penis had a large buildup of white smegma present. Staff A used a new washcloth with soap to clean the glans penis. She continued using the same area of the washcloth while applying new soap to the washcloth for the whole glans penis, removing the smegma until it appeared clean. She then used a new washcloth with soap to clean Resident #97's catheter tubing and scrotum. Staff A then used a new washcloth with clean water to wipe clean the resident's glans penis, catheter tubing, and scrotum. She then dried the area with a clean towel. After changing Resident #97's incontinence brief, Staff A and Staff B sat Resident #97 upright in the bed and covered him with his sheets, again, raising the catheter bag above the level of the bladder to hang the bag back on the bed frame. Neither Staff A nor Staff B replaced Resident #97's foreskin until after being reminded to do so by Resident #97 himself.</p> <p>An interview was conducted with the facility's Director of Nursing (DON) on 02/13/25 at 12:45 PM. The DON was told about the above concern with the catheter care, including the gloves in the pocket, unawareness of how to perform catheter care, and the lack of catheter securement device. The DON stated she planned to perform competencies on the staff as she also had concerns about staff members not understanding how to perform catheter care on uncircumcised residents.</p> <p>During the Quality Assurance and Performance Improvement meeting conducted on 02/13/25 at 1:00 PM, it was mentioned that, on 01/20/25, the facility administration had identified that nursing competencies regarding urinary catheter care were not up to date.</p> <p>Review of the facility's policy titled Catheter Care, Urinary, revision date 09/05/17 revealed the proper procedure for performing catheter care involved the following:</p> <p>Remove catheter securement device</p> <p>Wash perineal area with soap and water</p> <p>Rinse well and dry</p> <p>Clean catheter tubing with soap and water, starting at the meatus, cleaning in circular motion along its length, moving away from the body. Rinse well using the same motion</p> <p>Reattach catheter securement device</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951</p> <p>Based on observation, interview, and record review, the facility failed to ensure medical records contained complete and accurate information for 3 of 28 residents reviewed for medical records. (Residents #92, #5, #105)</p> <p>The findings include:</p> <p>Resident #92</p> <p>During a tour of the facility conducted on 02/10/25 at 12:33 PM, Resident #92 was noted receiving oxygen via a nasal cannula. Closer observation revealed the oxygen tubing was dated 01/26/25 (photographic evidence obtained).</p> <p>A review of Resident #92's medical record revealed she was admitted to the facility on [DATE]. Resident #92 had a medical history significant for Acute and Chronic Respiratory Failure, Apnea, Bipolar, Depression, and Dependence on Supplemental Oxygen. A review of Resident #92's Quarterly Minimum Data Set (MDS), dated [DATE], revealed she had a Brief Interview of Mental Status (BIMS) score of 15, which indicates she was cognitively intact. A review of Resident #92's Care Plan revealed a care plan was written on 10/01/24 regarding altered respiratory status, history of respiratory failure-oxygen via nasal cannula, change tubing . as ordered.</p> <p>A review of Resident #92's physician's orders revealed an order was written on 09/20/24 for Respiratory: Oxygen 2 liters nasal cannula Continuous every shift. Further order reviews revealed an order was written on 01/17/25 for Change oxygen tubing, mask and/or nasal cannula weekly. May change sooner as needed. Every night shift every Friday.</p> <p>A review of Resident #92's Treatment Administration Record (TAR) revealed a staff member documented the oxygen tubing was changed on 02/07/25 (photographic evidence obtained).</p> <p>Resident #5</p> <p>During a tour of the facility conducted on 02/10/25 at 12:40 PM, Resident #5 was observed receiving oxygen via a nasal cannula. Closer observation revealed the oxygen tubing was dated 01/26/25 (photographic evidence obtained).</p> <p>A review of Resident #5's medical record revealed he was initially admitted to the facility on [DATE] and was last readmitted on [DATE]. Resident #5 had a medical history significant for Paralysis, Chronic Obstructive Pulmonary Disease, Heart Failure, and Traumatic Brain Injury. A review of Resident #5's Quarterly MDS, dated [DATE] revealed he had a BIMS score of 8, which indicates he had moderate cognitive impairment. A review of Resident #5's Care Plan revealed there was no care plan written regarding oxygen use.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #5's physician orders revealed orders were written on 09/11/24 for Oxygen 2 liters per minute via nasal cannula as needed and Change tubing, mask and/or nasal cannula weekly. May change sooner as needed for hygiene AND every night shift every Friday.</p> <p>A review of Resident #5's TAR revealed a staff member documented the oxygen tubing was changed on 02/07/25 (photographic evidence obtained).</p> <p>An interview was conducted with Staff M, a Licensed Practical Nurse (LPN), on 02/12/25 at 2:50 PM. Staff M stated the night shift nurses were responsible for changing resident's oxygen tubing, but she could not confirm how often it was changed. She stated, to my knowledge, they are supposed to label it when it's changed.</p> <p>An interview was conducted with the facility's Director of Nursing (DON) on 02/12/25 at 4:05 PM. She stated the expectation would be for whoever performed care, such as changing oxygen tubing, would sign it off in the resident's medical record. In this instance, the night shift nurse should not have signed off that the oxygen tubing was changed. The DON further stated the expectation was that oxygen tubing would be changed weekly and labeled with the date of the change.</p> <p>Resident #105</p> <p>During a tour of the facility conducted on 02/10/25 at 12:45 PM, Resident #105 stated he had a peripherally-inserted central catheter (PICC) line in place for antibiotic use. Closer observation revealed the PICC dressing was dated 02/01/25. An interview was conducted with Resident #105 during this observation. He stated he did not know when the PICC dressing was changed last by the facility staff (photographic evidence obtained).</p> <p>A review of Resident #105's medical record revealed he was admitted to the facility on [DATE]. Resident #105 had a medical history significant for Cellulitis of the Right Upper Limb, Acute Osteomyelitis Right Hand, and Deep Vein Thrombosis. A review of Resident #105's Admission MDS, dated [DATE], revealed he had a BIMS score of 13, which indicates he was cognitively intact. A review of Resident #105's Care Plan revealed a care plan was written on 01/10/25 regarding he was on IV medications related to right 3rd finger Osteomyelitis and right-hand Cellulitis. A review of Resident #105's physician orders revealed an order was written on 01/15/25 for Change dressing on admission or 24 hours after insertion and weekly thereafter and as needed. Every day shift every Wednesday.</p> <p>A review of Resident #105's Medication Administration Record (MAR) revealed a staff member documented the PICC line dressing was changed on 02/05/25 (photographic evidence obtained).</p> <p>Additional observations were conducted on 02/11/25 at 12:20 PM and 1:45 PM of Resident #105's PICC line dressing, which remained dated 02/01/25.</p> <p>An interview was conducted with Resident #105 on 02/12/25 at 3:06 PM, in which he stated his PICC line had been removed the evening of 02/11/25.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with Staff M, LPN on 02/12/25 at 2:45 PM. Staff M stated the PICC line dressings were changed every three to five days. She said the staff should be assessing the PICC line dressings every time they go into the resident's room. She further stated the LPNs could assess the dressings, but a registered nurse had to perform the dressing changes. Staff M continued to explain that there was one nurse who performed the dressing changes on night shift and either the DON or Assistant DON who performed the dressing changes on day shift. Staff M confirmed that her initials were on the MAR as having signed off the PICC dressing change on 02/05/25. When asked why she signed off that the dressing change was completed on 02/05/25, she stated she would have told one of the nurses that Resident #105's PICC line was due for a dressing change and assumed the nurse had changed it.</p> <p>An interview was conducted with the facility's DON on 02/12/25 at 4:05 PM. She stated the expectation would be for whoever performed care, such as changing a dressing change, would sign off the resident's medical record. In this instance, the LPN should not have signed off that the PICC line dressing was changed. The DON further stated the LPN should have looked at the dressing to see if it had been changed and had the registered nurse sign off that the dressing change was completed.</p> <p>Review of the facility policy titled Departmental (Respiratory Therapy)-Prevention of Infection, date revised November 2011 revealed the staff should mark . with date and initials and change the oxygen cannula and tubing every seven days, or as needed.</p> <p>Review of the facility policy titled Guidelines for Preventing Intravenous Catheter-Related Infections, date revised August 2014 revealed the staff should change transparent semi-permeable membrane (TSM) dressings on central venous access devices every 5-7 days or as needed if damp, loosened, or visibly soiled and gauze dressing covered with TSM dressing should be considered a gauze dressing and changed at least every 48-hours.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951</p> <p>Based on observations, interview, and record review, the facility failed to maintain proper isolation precautions for 2 of 2 residents reviewed for Enhanced Barrier Precautions (EBP) (Resident #97 and #67), and the facility failed to ensure proper handwashing practices during medication administration opportunities for 2 of 20 observations (Resident #71 and #563).</p> <p>The findings include:</p> <p>Resident #97</p> <p>During a tour of the facility conducted on 02/10/25 at 12:50 PM, Resident #97 was noted with a urinary catheter present. Resident #97 stated the staff did not clean the catheter regularly.</p> <p>A review of Resident #97's medical record revealed he was initially admitted to the facility on [DATE] and was last readmitted on [DATE]. He had a medical history significant for Paraplegia, Hematuria, and Urinary Tract Infection. A review of Resident #97's Admission Minimum Data Set (MDS), dated [DATE] revealed he had a Brief Interview of Mental Status (BIMS) Score of 11, which indicates he had moderate cognitive impairment. This MDS documented the presence of the urinary catheter. A review of Resident #97's physician orders revealed there were orders written on 01/11/25 regarding Catheter care every shift and as needed and Enhanced Barrier Precautions.</p> <p>A urinary catheter care observation was conducted with Staff A, Certified Nursing Assistant (CNA), and Staff B, another CNA, on 02/13/25 at 10:33 AM. They gathered their needed supplies from a linen cart and entered Resident #97's room. Staff A and Staff B washed their hands and donned gloves. Staff A had a handful of gloves in her scrub top pocket that she used throughout the catheter care observation. Neither Staff A nor Staff B donned an isolation gown for performing the catheter care.</p> <p>Resident #67</p> <p>During the initial record review conducted on 02/10/25 at 3:34 PM, Resident #67 was noted with pressure injuries present on his left heel, left groin, right ischium, and sacrum.</p> <p>A review of Resident #67's medical record revealed he was initially admitted to the facility on [DATE] and was last readmitted on [DATE]. He had a medical history significant for Paraplegia, Malnutrition, Osteomyelitis, Colostomy, Depression, Atrophy, and Muscle Weakness. A review of Resident #67's Annual MDS, dated [DATE] revealed he had a BIMS score of 15, which indicates he was cognitively intact. This MDS documented the presence of pressure injuries. A review of Resident #67's physician orders revealed there were orders written on 11/08/24 regarding wound care procedures for each of his wounds.</p> <p>A wound care observation was conducted with Staff C, Licensed Practical Nurse, and Staff D, Nurse Practitioner. Staff C gathered supplies from the wound care cart prior to entering Resident #67's room. Staff C and Staff D washed their hands and donned gloves. Neither Staff C nor Staff D donned an isolation gown for performing the wound care.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951</p> <p>Based on record review and interview, the facility failed to ensure vaccination consents were obtained and maintained for 4 of 5 residents reviewed for Influenza and Pneumococcal Vaccinations (Resident #101, #51, #105, and #96).</p> <p>The findings include:</p> <p>A review of Resident #101's medical record for vaccinations revealed he was admitted to the facility on [DATE]. A review of the Immunization section of Resident #101's electronic medical record revealed he had refused the Pneumococcal vaccine. A review of the immunization consent forms provided by the facility revealed Resident #101 was missing a consent form for the Pneumococcal vaccine.</p> <p>A review of Resident #51's medical record for vaccinations revealed she was admitted to the facility on [DATE]. A review of the Immunization section of Resident #51's electronic medical record revealed she had refused the Influenza vaccine. A review of the immunization consent forms provided by the facility revealed Resident #51 was missing a consent form for the Influenza vaccine.</p> <p>A review of Resident #105's medical record for vaccinations revealed he was admitted to the facility on [DATE]. A review of the Immunization section of Resident #105's electronic medical record revealed he had refused the Pneumococcal vaccine. A review of the immunization consent forms provided by the facility revealed Resident #105 was missing a consent form for the Pneumococcal vaccine.</p> <p>A review of Resident #96's medical record for vaccinations revealed he was initially admitted to the facility on [DATE] and was last readmitted on [DATE] after an extended hospitalization which lasted approximately 3 weeks. A review of the Immunization section of Resident #96's electronic medical record revealed he had refused the Pneumococcal vaccine. A review of the immunization consent forms provided by the facility revealed Resident #96 was missing a consent form for the Pneumococcal vaccine from his initial admission in October 2024.</p> <p>An interview was conducted with the facility's Assistant Director of Nursing (ADON) on 02/13/25 at 11:10 AM regarding the missing Influenza and Pneumococcal vaccination consent forms. The ADON stated she would work with the Medical Records Department to find the missing consent forms. The ADON returned at 12:15 PM and confirmed she and the Medical Records personnel were unable to find the missing consents. The ADON then showed the surveyor a check list that the staff follow for each new resident admission, which contained directions that the staff are to obtain consents for Influenza and Pneumococcal vaccines. She stated in speaking with the Medical Records personnel that she was told, after things are scanned into residents' charts, the forms are then disposed of and not kept.</p> <p>Review of the facility's policy titled Influenza Vaccine, revised date March 2022 revealed the influenza vaccine shall be offered to residents, and a resident's refusal of the vaccine shall be documented on the informal consent for influenza vaccine and placed in the resident's medical record.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Aspire at the Gardens - Tallahassee		STREET ADDRESS, CITY, STATE, ZIP CODE 1650 Phillips Rd Tallahassee, FL 32308	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled Pneumococcal Vaccine, revised date March 2022 revealed residents are offered the vaccination within 30 days of admission to the facility, vaccines are administered to residents per our facility's protocol, and if refused, appropriate information is documented in the resident's medical record indicating the date of the refusal.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Aspire at the Gardens - Tallahassee		STREET ADDRESS, CITY, STATE, ZIP CODE 1650 Phillips Rd Tallahassee, FL 32308	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951</p> <p>Based on record review and interview, the facility failed to ensure vaccination consents were obtained and maintained for 3 of 5 residents reviewed for COVID-19 Vaccinations (Resident #101, #51, and #105).</p> <p>The findings include:</p> <p>A review of Resident #101's medical record for vaccinations revealed he was admitted to the facility on [DATE]. A review of the Immunization section of Resident #101's electronic medical record revealed he had refused the COVID-19 vaccine. A review of the immunization consent forms provided by the facility revealed Resident #101 was missing a consent form for the COVID-19 vaccine.</p> <p>A review of Resident #51's medical record for vaccinations revealed she was admitted to the facility on [DATE]. A review of the Immunization section of Resident #51's electronic medical record revealed she had refused the COVID-19 vaccine. A review of the immunization consent forms provided by the facility revealed Resident #51 was missing a consent form for the COVID-19 vaccine.</p> <p>A review of Resident #105's medical record for vaccinations revealed he was admitted to the facility on [DATE]. A review of the Immunization section of Resident #105's electronic medical record revealed he had refused the COVID-19 vaccine. A review of the immunization consent forms provided by the facility revealed Resident #105 was missing a consent form for the COVID-19 vaccine.</p> <p>An interview was conducted with the facility's Assistant Director of Nursing (ADON) on 02/13/25 at 11:10 AM about the missing COVID-19 vaccination consent forms. The ADON stated she would work with the Medical Records Department to find the missing consent forms. The ADON returned at 12:15 PM and confirmed she and the Medical Records personnel were unable to find the missing consents. The ADON then showed a check list that the staff follow for each new resident admission, which contained directions that the staff are to obtain consents for COVID-19 vaccines. She stated in speaking with the Medical Records personnel that she was told, after things are scanned into residents' charts, the forms are then disposed of and not kept. She said the Medical Records personnel also told her, Sometimes things get stuck together and that may have been why the consents were missing from the charts.</p> <p>A review of the facility's policy titled COVID-19 Vaccine-Resident, revised date 11/17/21 revealed the staff should review the COVID-19 consent with the resident/resident representative, obtain signature indicating acceptance or declination, and file the consent form in resident electronic health record.</p>		