STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105795	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Coral Bay	2939 S Haverhill Rd West Palm Beach, FL 33415

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 22517 Based on record reviews and interviews, the facility failed to provide evidence that allegations for abuse and neglect were thoroughly investigated. This is evidenced by the facility's failure to provide evidence conducting thorough investigations for 2 of 3 sampled residents (Residents #1 and #2). The findings included: Review of the facility's policy titled Abuse, Neglect, Exploitation & Misappropriation, Revision Date 11/16/22, documented regarding investigation: The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A Social Service representative may be offered in the role of resident advocate during any questioning of or interviewing of residents. Investigations will be accomplished in the following manner. Preliminary Investigation: Immediately upon investigation of abuse or neglect, the suspect(s) shall be segregated from residents pending the investigation of the resident allegation. The nurse or Director of Nursing/designee shall perform and document a through nursing evaluation and notify the attending physician. An incident report shall be filed by the individual in charge who received the report in conjunction with the person who reported the abuse. This report shall be filed as soon as possible in order to provide the most accurate information in a timely fashion, and submitted to the Abuse Coordinator. Investigation: The Abuse Coordinator and/or Director of Nursing shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared. 1) There were two separate incidents alleging neglect involving Resident #2. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	One incident occurred on 09/01/24 with Staff A and Staff D, when the resident alleged that Staff A yelled at him and he also had to sit in a soiled brief from 4 PM to 6 PM. The second incident occurred on 09/03/24 on the 3-11 shift with Staff B, alleging no one answered his call light from 9 PM to 11 PM. The resident alleged that he put his light on at 9:00 PM and no one answered his call light and did not provide care to him. There remains multiple questions left unanswered and the investigations lacked pertinent interviews, statements and reviews. Review of the facility's investigation for the first incident revealed the following: a.The 09/01/24 statement from Staff A, the male CNA, documented at 4:30 PM, he went to put Resident # 2 back to bed. The resident was very agitated, refused to go back to bed, saying profanity words to him. The CNA stated he left the resident's room because of agitation. After a half hour, the CNA stated he went back to the room, in front of the nurse, resident kept saying profanity word again to him. He left the room. b.The 09/05/24 statement from Resident #4, the roommate for Resident # 2, documented that the male CNA, Staff A, stripped the bed and Resident # 2 asked for a blanket. Staff A raised his voice and pointed his fingers at the resident. Resident # 2 stated I am not a child. Staff A stated I am just doing you a favor by helping you. Review of the facility's investigation for the second incident revealed: c.The 09/05/24 statement from Staff C, female CNA 11-7, documented another CNA was giving her report on another resident, when this resident was restless and yelling. So they went into the room together and they changed this resident. She stated she went to the pantry for a cup of water for this resident and took it to the resident's room. She left the room and she heard a call light and she noted that it was the call light for the room of Resident # 2 was on. She wrote that she went to the room and the resident reported to her that his light was on since 9 o'clock and no one answered the call light or the CNA came in and he had a bowel movement. She stated she checked his diaper but he did not and he told her he has been easing his body and he felt as if he did. But regardless no one attended to him or answered the call light since 9 o'clock. d.The 09/04/24 statement from Staff B noted that she worked Tuesday 3-11 on 09/03/24. Staff B noted that the resident was sitting in his wheelchair when she made her rounds, the resident asked her to put him in the bed. She went to get the supplies to clean the resident and she put him in the bed. She warmed his food and gave it to the resident, gave him water in his special cup, and put his boots on his feet. Then she went and took care of other residents. At 9:45 PM she went on break. At 9:00 PM she stated she was on the fllor and there were no lights on. When she came on duty on 09/04/24, the DON informed her the resident reported he put his light on at 9 PM on 09/03/24. She restated that there were no lights in the resident's room. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 09/18/24 at 2:00 PM with the Social Worker, she stated that Resident # 2 reported that Staff A disrespected him. The surveyor reviewed the statements and had multiple questions regarding the yelling incident and the care issues that Social Worker could not answer and the information was not documented in the facility's investigation folder. She stated that the Administrator is the Abuse Coordinator and they are in between Director of Nurses and the other DON would have investigated this. A telephone interview on 09/18/24 at approximately 3:00 PM with the previous DON. She stated that Resident # 2 and his mother came to talk with them on 09/04/24. She said that the resident reported that he didn't feel Staff A gave him respect. He was disrespected and that the staff yelled at him. The DON further stated that the resident didn't have a problem with care. However, the mother stated that if he did that, it may get worse and voiced that the CNA shouldn't care for him. The DON stated that the staff did yell and the resident used profanity. The nurse heard a commotion and the staff said he is cursing. The surveyor asked about the statement from the nurse because there was no statement from the nurse. She was unaware of a statement from the nurse. She further stated that the CNA, Staff A, was reassigned to the first floor and was provided an in-service. The surveyor also asked the DON about follow-up on the statement from the resident's roommate regarding the exchange between the CNA, Staff A, and the resident. She stated she was not aware of the statement from the roommate. The resident also reported a second incident from the following day of staff not providing care for him on 3-11 shift. She stated the aide (Staff B) gave him ice water around 5:30-6:00 PM. The nurse gave meds at 8:45 PM. The surveyor asked the DON, when was the last time the aide provided care to the resident. She was not sure. She further could not confirm if the resident received care or was checked from 9-11:30 PM. The resident reported that no one answered his call light when he put his light on at 9:00 PM. The 11-7 CNA, Staff C said she checked him after she came on at 11 PM. She stated that they suspended the CNA, Staff B, pending investigation and filed a report of neglect. The facility did not file a report regarding the verbal altercation with CNA Staff A. The surveyor asked about who was responsible for reviewing the investigations to ensure the investigation is complete. She stated she could not answer that. An interview was conducted on 09/18/24 at 3:22 PM with the Administrator. He is the person that should verify the investigation is complete. The surveyor asked him regarding the investigations for Resident # 2. He stated he didn't know why there wasn't an interview or statement from the nurse. He thought the nurse no longer worked for them. He stated he was not aware of the statement from the resident's roommate. An interview was conducted on 09/19/24 at 2:45 PM with Resident #2. He stated that Staff A, came in about 3:30-3:45 PM and put 2 blankets on the bed like pads. They had sent his blanket to the laundry. He said he needed a blanket to cover up and the aide said no more blankets. And a discussion between he and the aide and he was told don't touch the blanket and he said Staff A yelled at him. They continued to go back and forth so, he said, f--- you to the aide. The aide left and he said he had his roommate to take the blanket off the bed and put it aside. He said about 4:00 PM he had to go to the bathroom and he said he moved his bowels and had to stay in that BM until the nurse cleaned him up about 6:00 PM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 09/19/24 at approximately 2:50 PM with Resident #4. He said Staff A had stripped the bed and put 2 blankets on the bed. The resident had him to take one of the blankets off the bed and put it in the window. The aide came back and Resident # 2 and Staff A were going at it and he heard the aide say something about don't touch the blanket and heard Resident # 2 say I'm not a child and the aide left and said he wasn't doing him. The surveyor asked him did he see anything. He said he heard the commotion, so he got up to go toward Resident # 2 bed and he said the aide pointed his finger at the resident and yelled at him and then left the room. A telephone interview was conducted on 09/23/24 at 3:42 PM with the nurse on duty on 09/01/24, Staff D. She was walking by Resident # 2 room and the resident looked mad and he was talking to his roommate. The resident was ready to be put to bed. There were 2 blankets put on his bed as underpads. She said she would go get him a blanket and Staff A was going to get the Hoyer lift. When she came back with the blanket, They were going at it. Staff A said I'm not going to do him anymore. He said the resident said f--- you to him. The surveyor asked for clarification on her statement, they were going at it. She then stated she didn't hear what was specifically being said but she heard loud sounds of two different voices. Stop yelling and I knew it was about the blanket. She said she later approached Staff A about providing care for the resident and she would assist him but Staff A refused. She stated she had to clean up the resident. She stated she works 7 AM - 7 PM. So she said she reported to the oncoming shift that they needed to get another aide to care for the resident because Staff A refused to. 2) Review of the grievance log revealed a complaint/grievance filed by Resident #1 on 08/29/24, regarding a violation of rights. The resident alleged that the facility's administrator spoke to him in the therapy room about his living arrangements and his bill in front of two other residents and two therapists. A description of the concern noted by the Administrator documented, Resident stated that the Nursing Home Administrator spoke to him in therapy room. RE: resident bill. Event took place approximately 4:00 PM no other residents in room when discussion occurred just therapists. Findings of investigation: Spoke with the OT (Occupational Therapist) to confirm that no other resident was in therapy room at the same time that I spoke with Resident # 1. Results of action taken: Staff educated on giving resident privacy in private areas when speaking to them. The Investigation included a Witness statement from the Administrator and the Occupational Therapist as follows: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On 08/29/24 approximately 3:45 PM, I approached Resident #1 in the therapy room. He was in the room with the therapist. I asked how he was feeling. Resident #1 complained of his constant pain. I acknowledged his opinion. As it was just us in the therapy room, I asked him about his outstanding balance due to the facility. The outstanding balance and his patient responsibility that we are entitled to under the law. He stated that he needed the money for other personal expenses. He threatened to get outside counsel involved. I said that he has choice and left the therapy room. I provided privacy and confidentiality by taking him into the therapy room. b. A statement by the Occupational Therapist dated 09/04/24 documented Resident #1 was approached in Rehab room by our administrator. They discussed Business. Myself and my COTA (Certified Occupational Therapy Assistant) was in the room only. I left for part of the conversation to get Hot Packs. An interview was conducted on 09/19/24 at 10:30 AM with the Social Worker and she was asked regarding the investigation. She confirmed she did not have statements from the COTA, who was also allegedly present when the above incident occurred. There is also no evidence that the SW followed up with Resident #1 to identify the residents he said were present in the therapy room and once identified, there is no evidence of follow-up with the identied residents.

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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** 22517 Based on clinical and administrative record review and interviews, the facility failed to consistently provide effective pain management by failing to obtain pain medication refills in a timely manner to ensure 1 of 3 residents reviewed (Resident #1), did not have extended periods of time without pain medications. The findings included: Review of the clinical record for Resident # 1 revealed that the resident was admitted to the facility on [DATE] with pertinent diagnoses which included: Intervertebral disc displacement lumbar region, pain in left foot, pain in right foot, low back pain, pain in joints of right hand, opioid dependence with other opioid-induced disorder, idiopathic peripheral autonomic neuropathy, peripheral vascular disease, and Diabetes Mellitus with Diabetic Neuropathy. Review of the physician prescriptions revealed that the physician prescribed on 08/08/24 Dilaudid Oral Tablet 8 mg (Hydromorphone HCL) Give 1 tablet by mouth every 8 hours as needed for pain per pain management; and Xtampza ER Oral Capsule ER 18 mg Give 1 capsule by mouth every 12 hours for pain. Then on 08/28/24, the physician prescribed further clarification regarding the as needed medication and prescribed Dilaudid Oral tablet 8 mg (Hydromorphone HCL) Give 1 tablet by mouth every 8 hours as needed for Pain. DO NOT GIVE WITHIN 2 HOURS OF Xtampza 18 mg. Review of the Medication Monitoring/Control Record revealed a control sheet for Xtampza ER Cap 18 mg 1 capsule by mouth every 12 hours. The nurse signed on 08/09/24, 28 tablets was received. The sheet documented every 12 hours the administration of the 28 prescribed medication from 08/09/24 at 10:00 AM until 08/22/24 9:00 PM. The next sheet does not report the prescribed medication was administered until 08/25/24 at 9:00 AM (2 days later). There is no evidence that the resident received the routine every 12 hour medication on 08/23/24 and 08/24/24 (4 doses). Further review of the Medication Monitoring/Control Record for Dilaudid /Hydromorphone tab 8 mg one tablet by mouth every 8 hours as needed for pain revealed that the nurse signed that 30 tablets was received on 08/09/24. The staff documented administering the 30 tablets as needed medication from 08/14/24 at 5:00 AM to 08/24/24 at 5:00 AM. Further review of the distribution of the as needed medication, the resident consistently received three as needed doses everyday during this time period. There is no evidence that the resident received additional doses of the as needed pain medication until 08/26/24 at 04:55 AM. The controlled sheet documented that 25 tablets were received on 08/26/24. Again the resident did not receive pain management medication for two days, 08/24/24 and 08/25/24 (6 possible doses were not available to be administered for those two days). Review of some of the pain monitoring documentation during the above 2 day span, when the resident's pain management medication was unavailable, revealed that the nurses documented the following, on a scale of 1-10, 10 being the worst): 08/22/24 -10:00 PM -5 08/23/24 - 5:00 AM - 5 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/23/24 - 1:40 PM - 8 08/24/24 - 5:00 AM - 5 08/25/24 -1:02 PM - 6 08/26/24 -12:20 PM - 5 08/26/24 - 2:11 PM - 9 An interview was conducted with the Director of Nursing on 09/19/24 at approximately 12 noon, the surveyor reviewed with her, the Medication Monitoring/Control Records and Medication Administration Record discrepancies. She confirmed that the Xtampza is not in the facility's emergency medication kit. Thus, the resident would not have received those doses, despite the nurse signing the Medication Administration Record to document that the medication was administered. Although, the Dilaudid is medication that is available in the emergency medication kit, the nurse would have to contact pharmacy to get approval to take the medication out and complete a form to document this removal, the facility did not provide any evidence that this occurred. An interview was conducted on 09/19/24 at 3:15 PM with Resident #1, who reported that the last few weeks, the staff have run out of his medications. He further stated about 2-3 weeks ago, he went 32 hours without his extended pain medications and 42 hours without his other pain medication. The staff wait until the medication is out before reordering. He further stated he kept asking for pain medication and he was told it was being order, then he later found out that the nurse did not order. He stated he was in so much pain, he was crying and he stated he kept following up with the nurses, and he was told it was ordered. There is no sense of urgency in this building. He stated he is in pain all the time pointing to his legs and stated he also applies ice pack in the area to help try to ease the pain some. Further review of the Resident #1's Minimum Data Set (MDS) Quarterly assessment dated [DATE] documented that the resident's Brief Interview for Mental Status (BIMS) score was 15 (on a scale of 0-15, 15 being alert and oriented and does not identify memory impairment). Pain Management the resident received scheduled pain medication regimen and received PRN (as needed) pain medication. The facility identified a concern on 02/07/24 and the care plan was revised on 03/07/24 as the resident is at risk for pain related to chronic illness, physical impairment. Interventions included Administer analgesia as per orders, notify the MD if pain management is not effective; Anticipate the resident's need for pain relief and respond immediately to any complaint of pain; Evaluate the effectiveness of pain interventions per orders. Review for compliance, alleviating of symptoms, dosing schedules and resident and resident satisfaction with results, impact on functional ability and impact on cognition; Monitor/document for side effects of pain medication; Monitor/record/report to Nurse any s/s (sign and symptoms) of non-verbal pain; Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 22517 Based on clinical and administrative record review and interviews, the facility failed to ensure that the staff consistently implemented the system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications. Failed to ensure prompt identification of loss or potential diversion of controlled medications and the determination of the extent of loss or potential diversion of controlled medications for 3 of 3 residents (Residents #1, #2 and #3). The findings included: 1) Review of the clinical record for Resident # 1 physician prescriptions revealed that the physician prescribed on 08/08/24 Dilaudid Oral Tablet 8 mg (Hydromorphone HCL) Give 1 tablet by mouth every 8 hours as needed for pain per pain management, and Xtampza ER Oral Capsule ER 18 mg Give 1 capsule by mouth every 12 hours for pain. Review of the Medication Monitoring/Control Record and the corresponding Medication Administration Record (MAR) revealed that the nurses did not consistently document the administration of the Dilaudid/Hydromorphone tab 8 mg one tablet by month every 8 hours as needed for pain on the Medication Administration Record. Further review of the Medication Monitoring/Control Record for Dilaudid /Hydromorphone tab 8 mg 08/01/24 - 08/30/24 the nurses documented they removed 116 doses. However, the corresponding MAR for August revealed that the nurses failed to document 12 doses as follows: 1. 08/08/24 - three doses were not documented at 4:20 AM, 1:00 PM and 6:30 PM 2. 08/12/24 - one doses at 1:00 PM 3. 08/13/24 - two doses at 5:00 AM, 1:00 PM. Additionally another dose was documented as administered at 7:00 PM 6 hours from the last dose signed out as administered on the Control Record. This documentation failure permitted the every 8 hour as needed pain medication to be administered within 6 hours. The nurse at 7:00 PM documented that the resident's pain was at level 5 on a scale of 0-10 with ten being the most severe. 4. 08/14/24 - one dose at 1:00 PM 5. 08/15/24 - one dose at 2:00 PM. Additionally another dose was documented as administered at 7:00 PM, 5 hours from the last dose signed out as administered on the Control Record. Again this documentation failure permitted the every 8 hour as needed pain medication to be administered within 5 hours. The nurse at 7:00 PM documented that the resident's pain was at level 5. 6. 08/20/24 - one dose at 6:30 PM. Additionally another dose was documented as administered at 10:00 PM, 3 1/2 hours from the last dose signed out as administered on the Control Record. Again this documentation failure permitted the every 8 hour as needed (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pain medication to be administered within 3 1/2 hours. The nurse at 10:00 PM documented that the resident's pain was at level 8. 7. 08/21/24 - one dose at 2:50 PM. 8. 08/23/24 - one dose at 9:00 PM. 9. 08/28/24 - one dose at 1:00 PM. In September, there were 27 doses documented on the Control Record as being administered until 09/17/24. However, the corresponding MAR for September revealed that the nurses failed to document 6 doses as follows: 1. 09/02/24 - one dose at 7:50 AM. 2. 09/04/24 - two doses at 7:00 AM and 3:00 PM 3. 09/07/24 - one dose at 7:00 PM 4. 09/12/24 - one dose at 10:00 PM 5. 09/17/24 - one dose at 2:30 PM 2) Review of the clinical record for Resident #2 revealed that the physician prescribed for the resident to receive Tramadol HCL Oral tablet 50 mg, give 1 tablet by mouth every 12 hours as needed for chronic pain. Further review of the Medication Monitoring/Control Record and the corresponding Medication Administration Record (MAR) revealed that the nurses did not consistently document the administration of the Tramadol on the MAR. The August Control Record documented 61 doses removed. However, the August MAR failed to document seven doses as follows: 1. 08/03/24 - one dose at 10:45 PM 2. 08/04/24 - one dose at 9:00 PM 3. 08/17/24 - one dose at 10:00 PM 4. 08/19/24 - one dose at 10:00 AM 5. 08/20/24 - one dose at 11:00 PM 6. 08/21/24 - one dose at 10:00 PM 7. 08/23/24 - one dose at 10:00 PM The September Control Record documented 31 doses being removed from 09/01-09/17/24. However, the corresponding MAR failed to document five doses as follows: 1. 09/01/24 - one dose at 9:00 PM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. 09/06/24 - one dose at 9:00 AM 3. 09/0724 - one dose at 10:00 PM 4. 09/08/24 - one dose at 10:00 PM 5.09/17/24 - one dose at 10:54 PM An interview was conducted on 09/19/24 at approximately 12:00 Noon with the Director of Nursing. The DON confirmed that the nurses are to document the removal of the medication on the Control Record and document the administration of the medication on the Medication Administration Record. The surveyor reviewed with her the multiple record discrepancies for Residents #1 and #2. There are discrepancies between the Control Record and the MAR and the nurses failed to consistently document the medication administration on the MAR. 3) Review of the clinical record for Resident #3 revealed that the physician prescribed for the resident to receive Oxycodone HCL Oral tablet 15 mg, give 1 tablet by mouth every 6 hours as needed for pain. The September Control Record documented that the nurses removed 22 doses of the Oxycodone from 09/01/24 - 09/19/24. However, the corresponding MAR for September revealed the nurse failed to document 12 doses on the MAR as follows: 1. 09/06/24 - one dose at 6:00 PM 2. 09/07/24 - one dose at 6:00 AM 3. 09/08/24 - two doses at 6:00 AM and 6:00 PM 4. 09/09/24 - one dose at 12:00 PM 5. 09/14/24 - two doses at 12:00 AM and 6:00 AM 6. 09/15/24 - one dose at 6:00 PM 7. 09/16/24 - one dose at 6:00 PM 8. 09/18/24 - two doses at 12:18 AM and 6:08 AM 9. 09/19/24 - one dose at 6:00 AM An interview was conducted on 09/19/24 at approximately 2:30 PM with the Director of Nursing. The surveyor reviewed with her the continued pattern of the nurses failing to document the administration of medication and the multiple discrepancies between the Control Record and the MAR. The nurses are failing to consistently document the medication administration on the MAR.