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	04/10/2025

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50895 Based on observations, record reviews, and interviews, the facility failed to maintain the call device within reach for 1 of 10 residents observed (Resident #83). The findings included: A record review revealed that Resident #83 was admitted to the facility on [DATE]. Her diagnoses included Chronic Obstructive Pulmonary Disease, Emphysema. The Minimum Data Set assessment dated [DATE] showed Resident #83's BIMS was 00 which indicated that Resident #83 had significant cognitive impairment. During observations on 04/07/25 at 12:00 PM, 04/08/25 at 8:00 AM, 04/08/25 at 5:14 PM, and 04/09/25 at 8:05 AM, the call device was located on the floor beneath Resident #83's bed. The call bell was not within reach of Resident #83. During an interview with Resident #83 on 04/09/25 at 11:30 AM, the surveyor asked the resident if she knew what the white plastic covered piece, the call bell, was used for. The surveyor held it in the surveyor's hand to show it to the resident. The resident answered yes, that's the call bell. When asked if she knew what the call bell was used for Resident #83 answered yes. I press it when I want the nurse to come in. The surveyor asked the resident if she had used it before and the resident answered yes. Multiple interactions with Resident #83 demonstrated that Resident #83 was able to carry on a conversation, and she answered questions appropriately. When Resident #83 was asked if she was comfortable with the head of the bed in the elevated position of approximately 35 degrees, Resident #83 said she preferred it to be higher. When asked if she required assistance in repositioning the head of the bed, Resident #83 said no. She said that she could do it herself. Resident #83 picked up the control for the bed and she elevated the head to the position that she preferred.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to provide maintenance and housekeeping services in a manner to provide a safe, clean, home like environment. The findings included: 1). In the common area inside of the lobby/reception area, at the entrance to the courtyard, it was noted that there were 14 out of 16 lights that did not work and that another light was flashing off and on. 2). In the Main Dining Room on the second floor, the following were noted: A. There was an unidentified residue on the windows and the tint that was applied to the interior of the windows was peeling. B. there was an accumulation of dust in the air vent over the hand washing sink. C. The ceiling inside of the entrance to the second floor was unfinished and needed to be sanded and painted. 3). The frame and the door to the elevator by the Main Dining Room on the first and second floor was noted to have areas of peeling paint and linoleum on the floor in the elevator was peeling and damaged. 4). In the courtyard, the top of a canopy/shelter was torn and in disrepair and there was a screen that had fallen from one of the attached Assisted Living units that had fallen into the courtyard that was left for the duration of the survey. 5). On the second floor units, the following were noted: a. In room [ROOM NUMBER], there were scuff marks on the wall by the wall mounted air conditioning unit. Paint was missing from the corner of the wall exposing what appeared to be rust underneath by the window. The filters in the air conditioning unit were torn, and there was some residue on the left arm of the room chair. b. In room [ROOM NUMBER], there were brown spots on the wall to the left of the window and there was an accumulation of debris in the wall mounted air conditioning unit. c. In room [ROOM NUMBER], the privacy curtain between the beds was stained and the filters in the wall mounted air conditioning unit were dirty. There was a dried fluid on the top of the dresser of Bed A. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. In room [ROOM NUMBER], the over bed table for the B bed was held with a piece of tape and worn to a point that the particle board underneath was exposed. The hand sink in the shared bathroom was constantly running. e. In room [ROOM NUMBER], there was a hole in the door to the shared restroom and the wall to the left of the wall mounted air conditioning unit was damaged where the baseboard was not attached securely to the wall. f. In room [ROOM NUMBER], there were rub marks on the wall on both sides of the A bed dresser. g. In room [ROOM NUMBER], the floor tiles under the wall mounted air conditioning unit were separating and the adhesive was exposed, the exterior of the room entry door was noted to have scratches across the bottom, there was a hole in the exterior of the bathroom door. The baseboard and wall by the entrance to the room (in the corridor) to the right of the door was damaged in a manner that part of the baseboard was missing and there was a hole in the wall. During an environmental tour, on 04/10/25 at 8:14 AM, the Maintenance Director acknowledged the findings. While in the Main Dining Room on the second floor, the Maintenance Director placed his hand on the window and described the surface of the window as 'tacky'.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52248 Based on record review and interviews the facility failed to file a grievance in a timely manner for 1 of 8 sampled residents, as evidenced by Resident #55 who had been missing her clothing for almost a month. The findings included: Record review revealed Resident #55 was admitted to the facility on [DATE]. Review of the current Minimum Data Sheet (MDS) dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating no cognitive impairment. During an interview on 04/07/25 at 9:42 AM, when asked if she was getting everything she needed, Resident #55 stated, I have not gotten any of my clean clothes back in almost a month. When asked how long she had been at the facility, Resident #55 stated, I have been here a little over a month. During an interview on 04/08/25 at 9:51 AM, when Resident #55 was complimented on the dress she was wearing, she stated, It's not mine. I haven't had my laundry back in 3 to 4 weeks. During an interview on 04/08/25 at 10:32 AM, when asked if she knew that Resident #55 had missing clothes, the Regional Social Worker stated, I'm not aware, I will have to look into it and let you know. During an interview on 04/09/25 at 9:36 AM, when asked if she had spoken to Resident #55 about her missing clothes, the Regional Social Worker stated I spoke to the resident regarding her missing clothes. She was missing 5 pairs of pants and 5 shirts. The previous social worker documented that the resident didn't come here with any belongings. I spoke to the social worker, at the sister facility she came from, and she said the resident definitely left the facility with clothing. When asked if there was an inventory sheet done for the resident on admission, the Regional Social Worker stated, I'm not sure yet, that's part of my investigation, but I did start a grievance. During an interview on 04/09/25 at 9:48 AM, when asked where the inventory sheet was kept that is filled out for a resident on admission, the Nursing Supervisor stated, In the chart. Whose inventory sheet are you looking for? The Nursing Supervisor looked in the chart and stated, I don't see one for her, give me a moment. Review of a progress note on 04/09/25 at 10:09 AM, revealed documentation of a conversation dated 04/08/25, that the Regional Social Worker had with social service at Aspire at the Sea in Pompano, where the resident resided prior, indicated that the social service reported that he walked Resident #55 out to the car on the day she was discharged with all of her belongings and none of the resident's belongings were left at the facility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/25 at 9:46 AM, when asked for an update on the grievance for Resident #55, the Regional Social Worker stated, Here is a copy of the grievance I started, but it's not completed as of yet. A copy of the grievance dated 04/8/25 for Resident #55 was provided by the Regional Social Worker.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52248 Based on record review and interviews the facility failed to provide a PASRR (Preadmission Screening and Resident Review) Level 2 when the Level 1 screening indicated the need, for 1 of 24 sampled residents (Resident #57). The findings included: Record review revealed Resident #57 was readmitted to the facility on [DATE]. The current Minimum Data Set, dated dated dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score 15, on a 0-15 scale, indicating no cognitive impairment. Review of Resident #57's medical diagnoses on 04/08/25 indicated that she had a history of anxiety disorder (excessive worry about situations) and bipolar disorder (mental illness that causes intense shift in mood). Review of a PASRR Level 1 for Resident #57 dated 05/26/22, did not indicate that Resident #57 had a diagnosis of anxiety disorder. Review of a psychotherapy note dated 08/14/23, documented Resident #57 had a history of depression associated with bipolar disorder due to loss of independence with declining health and functional ability. A second psychotherapy note dated 11/01/23, documented Resident #57 had a diagnosis of bipolar and anxiety. During an interview on 04/08/25 at 10:32 AM, when asked if there was a more current PASRR Level 1 done that indicated Resident #57's current mental disorder diagnosis, the Regional Social Worker stated, She should have a more current one. The Regional Social Worker went to Acentra Health (Florida's provider for PASRR) online and stated Yes, she had a more recent one dated 09/29/23, but it still does not include the bipolar diagnosis. It still indicated that she needed a PASRR Level 2 due to her other diagnosis and it wasn't done. Review of the PASSAR Level 1 for Resident #57 dated 09/29/23, revealed that signs of serious mental illness or a related condition was found and a PASRR Level 2 was needed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interviews and record review; the facility failed to provide Physician ordered wound care post dermatology procedure for 1 of 1 resident sampled for skin condition (Resident #104). The findings included: Resident #104 was admitted to the facility on [DATE] with diagnoses that included Cerebral Infarction, and Atrial Fibrillation. His Brief Interview for Mental Status (BIMS) score was 14 on the quarterly Minimum Data Set (MDS) with an assessment reference date of 03/08/25. This indicated the resident had intact cognition. On 04/07/25 at 10:19 AM an interview was conducted with Resident #104. He stated he had a [NAME] procedure to his upper back. When he went back to the dermatologist for a follow up visit, the Physician told him he had an infection in the wound because wound care was not done. Record review revealed the resident had a [NAME] (a precise micrograpic surgery to remove skin cancer) procedure on 03/10/25 at a dermatologist's office. The resident returned to the facility with orders to wash biopsy area to upper back with soap and water, apply Vaseline or Mupirocin to the wound, apply Telfa and adhere with paper tape, if severe redness, oozing, pain, fever or chills call the office. This order was not seen on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) when reviewed. An interview was conducted with the Director of Nurses (DON) on 04/09/25 at 11:15 AM. The DON reviewed the resident's orders post [NAME] procedure. She stated the orders were put in the electronic health record but not directed to the MAR or TAR so the treatment was not done. Further record review revealed the resident returned to the dermatologist on 03/25/25 and received a new order to clean area with soap and water. Appy mupirocin once a day. The dermatologist then ordered an antibiotic-Cefadroxil 500mg (milligrams) 1 by mouth twice a day x 7 days, take with food.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to provide supervision to prevent the elopement of 1 of 3 residents reviewed for wandering and elopement, Resident #81. The findings included: The facility's policy 'Elopement/Wandering Risk Guideline' with a reference date of 09/21/16 and a revision date of 08/01/20, provided by the facility did not address 1:1 supervision to prevent elopement. Record review for Resident #81 revealed that the resident was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Quarterly Minimum Data Set (MDS), dated [DATE], Resident #81 had a Brief Interview for Mental Status (BIMS) score of 01. Progress notes and Interviews with staff confirmed that the resident was alert and oriented and able to make his own decisions for day to day activities. The MDS documented that Resident #81 displayed wandering behaviors each day of the 7-day look back period. The assessment documented that the resident required 'Supervision or touching assistance' for bed mobility and ambulated with minimal assistance. Resident #81's diagnoses at the time of the assessment included: Hypertension, Diabetes Mellitus, , Hip fracture, Seizure disorder, Malnutrition, Anxiety disorder, Depression, Left hip pain, Muscle weakness, Need for assistance with personal care, Cognitive communication deficit, Mood (Affective) disorder, Dependence on renal dialysis. Resident #1's care plan for wandering/elopement, initiated on 05/03/24 and most recently revised on 03/14/25 (upon most recent elopement), documented, Resident is an elopement risk/wanderer related to history of attempts to leave facility unattended. Resident had an elopement 6/19/24 elopement x2 ,7/1/24 attempted to push door open to leave facility, 3/14/25 resident left building unattended and brought back safely. The goal of the care plan was documented as, The resident will not leave facility unattended through the review date. Date Initiated: 05/03/2024 Revision on: 02/25/2025 Target Date: 05/26/2025. Interventions to the care plan included: o (3/14/25): Patient room changed away from exit doors. Continue to monitor frequently his whereabouts Date Initiated: 03/13/2025 Revision on: 03/14/2025 o Assess for elopement risk. Date Initiated: 05/03/2024 Revision on: 10/04/2024 o Constant supervision for safety Date Initiated: 01/01/2025 o Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book per resident preference Date Initiated: 05/03/2024 Revision on: 10/04/2024 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Electronic monitoring device. Date Initiated: 06/20/2024 Revision on: 10/04/2024 o Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Date Initiated: 05/03/2024 Revision on: 10/04/2024 o psych consult ordered Lab ordered Date Initiated: 06/19/2024 Resident #81's most recent Elopement Risk Evaluation, dated 01/15/25, documented that the resident was an elopement risk due to the following factors: Resident is cognitively impaired Resident is independently ambulatory Has poor decision making skills Has demonstrated exit seeking behaviors Wanders oblivious to safety needs Has a history of elopement Has the ability to exit the facility On 03/14/25 at approximately 4:15 AM, Resident #81 exited the facility through a door at the end of the 120 unit that was equipped with alarms and was located by facility staff and law enforcement at the entrance to the bus loop of the local high school and returned to the facility 54 minutes later. A progress note, dated 3/14/2025 at 06:56AM , documented, Note Text: Upon his return to the facility, writer conducted a comprehensive head-to-toe assessment on the resident, confirming no new skin impairment, and resident denied pain. During the assessment, writer took the opportunity to remind the resident on the potential dangers of leaving the facility unattended. The resident nodded his head in agreement, and stated, Are you guys ok? I didn't mean to get you guys in trouble, I just want to get to my house, my sister think that I don't have a house, but I do. Resident was seen and evaluated by ARNP, new orders received and implemented. Efforts to contact the resident's sister were made but unfortunately proved unsuccessful, all safety precautions, including 1:1 in place. As documented by the Director of Nursing (DON). During an interview, with Resident #81, on 04/07/25 at 11:53 AM, when asked about exiting the facility, Resident #81 replied, I was trying to go home in Pompano. I was going to take a bus to Dixie Highway (in Lake Worth Beach) and then another bus can take me to Pompano. Resident #81 confirmed that the alarm sounded when he attempted to open the door. Resident #81 further stated, I don't like this place. I would rather be home. I am on dialysis. Resident #81 confirmed he was located by the high school by local law enforcement and facility staff and returned to the facility. Resident #81 was noted with wander guard to left ankle. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing assignments for the shift and time that Resident #81 exited the facility revealed documentation that there were supposed to be 4 CNAs on the shift and that one of the CNAs did not call in or show up for the shift. During an interview, on 04/08/15 at 11:57 AM, with Staff I, Assigned LPN, when asked about Resident #81 eloping from the facility, the LPN replied, Basically, the patient eloped and the alarm went off to alert us. When I responded from the hall that I was at - I was a little further down the hall - I saw the CNA sitting with the patient and I left to take care of another patient. While in another room, I heard an alarm go off and when I went out to answer the alarm, there was another resident, and I asked if he pushed the door open and he said 'No'. I noticed that the CNA that was sitting with him was not there and I thought that he might have been in the shower with the CNA or in the courtyard. When I could not find the patient, I used the overhead pager to alert staff and initiate a search. I was working with another nurse, and she went outside to search with another CNA and she found him by the bus loop at the high school. The [NAME] had also responded while they were with the resident after finding him. The LPN further stated, The CNAs were rotating 1:1 each hour and the CNA left to take care of another patient. During an interview, on 04/09/25 at 6:34 AM with Staff J, CNA, when asked about providing 1:1 supervision to Resident #81 and how the resident managed to exit the facility, Staff J replied, I was on his door, my time was up and another CNA relieved me. I went to my regular assignment, we had 19 residents each that night because of a CNA that no call/no showed for the shift, there were 3 when there should have been 4. They were trying to get someone. Everyone takes an hour at a time at the door. He was calm and I left him and his roommate sleeping when I left the door. When I relieved the CNA (referring to Staff J), he was awake and agitated at the beginning of my rotation. During an interview, on 04/09/25 at 6:40 AM, with Staff K, CNA, when asked about the 1:1 supervision provided to Resident #81 and how the resident managed to exit the facility, Staff K replied, I relieved her at 3:00 AM, at 4:00 I left the door, my time was up. The CNA (Referring to Staff L) that was supposed to relieve me was at the nursing station and I went back to my assignment. The nurse called me (referring to Staff I). When I went back to my assignment, I heard the alarm at the door. I went to the other side, and I checked the door to see if it could open. I went to the other door where staff enter and leave. During an interview, on 04/09/25 at 7:10 AM with the DON, when asked about the staff member that did not show and how it was accounted for, the DON replied, I was not notified, the nurse decided on the rotation that night. The CNA that was on rotation was at the nurse's station (Referring to Staff L) she assumed that she was heading there because she was at the nurse's station. If we knew about it, we would have called somebody in. We are in the process of terminating the CNA that did not showup for work. Before the 11-7 supervisor leaves, he is responsible for 1:1 with the resident, Staff J was at the door. When the CNA did not show up for work, Staff I decided to do the hourly rotation, and the CNAs agreed, and everyone was asleep. He (referring to Resident #81) gets up at 5AM every morning, he is aware, he won't try anything if he sees the Administrator or I. We have been trying to find placement for him, but it is hard because of the dialysis and he needs a secured unit. On 04/09/25 at 8:00 AM, a message was left with Staff L, CNA. There was no response from the CNA.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50895 Based on observations, record reviews, policy review, and an interview, the facility failed to provide respiratory care in accordance with Professional Standards of Practice for 2 Residents (Residents #61, #54) of 2 residents reviewed for respiratory care. The findings included: According to a review of the Policy and Procedures for Oxygen Therapy, the procedure for oxygen therapy included to start the oxygen flow rate at the prescribed liter flow. 1. Resident #54 was admitted to the facility on [DATE]. Her diagnoses included Heart Failure, Morbid Obesity, and Chronic Obstructive Pulmonary Disease. A review of the Minimum Data Set (MDS) quarterly assessment completed on 02/16/25 revealed that Resident #54 had a Brief Interview for Mental Status score of 14, this indicated that she was cognitively intact. The focus of Resident #54's care plan last revised 02/06/24 said that the resident had respiratory issues related to shortness of breath, and that the resident received oxygen therapy secondary to Congestive Heart Failure. A record review showed Resident #54's care plan had a goal that stated the resident will have no signs and symptoms of poor oxygen absorption through the review date. This care plan was last revised on 08/29/24. An intervention listed said that the oxygen settings should provide oxygen per the (doctor's) order. Resident #54 had a doctor's order dated 07/06/23 to provide oxygen as needed at 2 Liters per minute. During an observation on 04/08/25 at 10:42 AM, the surveyor checked the oxygen concentrator to view the concentration of the oxygen that was being delivered via nasal cannula. The oxygen was delivered at 3 Liters per minute. The directions in the doctor's order specified 2 Liters per minute. On 04/09/25 at 8:00 AM, 04/09/25 at 10:45 AM, and 4/10/25 at 11:22 AM, the oxygen level was set at 3.5 Liters per minute. Photographic evidence obtained. During an interview with Staff G (a Licensed Practical Nurse), on 04/10/25 at 11:22 AM, when asked to describe the oxygen level that Resident #54's concentrator was set on, Staff G said it was more than 3. The surveyor asked if it was set at 3.5 Liters per minute, and Staff G agreed with this finding. 2. A record review of Resident #61 revealed that she was admitted to the facility on [DATE]. Her diagnoses included Morbid Obesity, Shortness of Breath, and Generalized Muscle Weakness. A review of the Minimum Data Set (MDS), admission assessment completed on 02/03/25, revealed that Resident #61 had a Brief Interview for Mental Status (BIMS) score of 12. This indicated that she was cognitively intact. A record review showed a doctor's order dated 03/21/25 for oxygen to be administered at 2 Liters per minute via nasal cannula as needed to maintain saturations above 92%. A nursing progress note on 04/07/25 stated that Resident #61 was on continuous oxygen at 2 Liters via nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the initial observation on 04/07/25 at 4:08 PM, Resident #61 was in bed receiving oxygen via nasal cannula. The oxygen concentrator was set between 1-1.5 Liters per minute. The concentrator should have been set on 2 Liters per minute per the doctor's order. Observations on 04/09/25 at 10:25 AM, 04/10/25 at 8:13 AM revealed oxygen levels at 1.5 L. Photographic evidence obtained. During an interview with Staff G (a Licensed Practical Nurse), at 04/10/25 at 11:35 AM, the surveyor viewed the level of oxygen on the concentrator at eye level. The level was set at 1.25 Liters per minute. When Staff G was asked what the level of oxygen was set at, she answered that it was set at less than 2 L. When Staff G was asked if it was set at 1.25 Liters per minute, Staff G agreed with this finding.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 52248 Based on policy review, observation, record review, and interview, the facility failed to follow proper procedure for providing side rails as evidenced by failure to do an evaluation and get a consent signed prior to installing side rails for 1 of 24 residents observed (Resident #422). The findings included: Review of the policy titled Side Rail/Bed Rail dated 04/19/2018, documented, in part, Procedure: Prior to installation of a side rail/bed rail complete the side rail/bed rail evaluation to evaluate the resident for risk of entrapment. Review the risk and benefits with the resident or representative. Obtain consent from the resident or resident representative. Obtain physician order for side rail/bed rail. Update the care plan and kardex. An observation on 04/09/25 at 1:52 PM, revealed bilateral one quarter side rails on Resident #422's bed. During an interview on 04/09/25 at 1:58 PM, when asked when he got the side rails, Resident #422 stated, They put them on this afternoon. The sister of Resident # 422 stated, They put them on today. I requested them, because he keeps falling out of bed and I'm afraid he is going to hurt himself. He had another fall last night. Record review on 04/09/25 and on 04/10/25 at 9:06 AM revealed that there was no documentation of a completed evaluation, prior to the side rails being installed for Resident #422. During an interview on 04/10/25 at 10:10 AM, when asked when the side rails were installed for Resident #422, the DON stated On yesterday because the mother requested them. When asked if the mother signed a consent, the DON stated It's a verbal consent with the mother and it should be in his record. When asked if an assessment was done prior to the side rails being installed for Resident #422, the DON stated, It was done by therapy I will get a copy for you. During an interview on 04/10/25 at 1:10 PM, when asked why she provided a copy of the therapy admission evaluation dated 04/03/25, the DON stated, I thought that's what you needed. When asked if nursing is responsible for doing an assessment as well, the DON stated, I didn't know nursing had to do one when the side rails are requested by the family. The DON then provided a copy of a side rail evaluation that she had completed with the date of 04/10/25 at 10:17AM.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interviews, record and policy review, the facility failed to provide a well-balanced diet that meets nutritional needs and honors residents' preferences for 2 of 5 residents sampled for food preferences (Resident #16 and Resident #51). The findings included: The facility's policy titled Dining and Food Preferences which originated 05/2015 and revised and 10/2022 revealed The Registered Dietician/Nutritionist (RDN) or other clinically qualified nutrition professional will review, and after consultation with the resident, adjust the individual meal plan to ensure adequate fluid volume and appropriate nutritional content for residents/patients that do not consume certain foods or food groups. The individual tray assembly ticket will identify all food items appropriate for the resident/patient based on diet order, allergies and intolerances, and preferences. 1. Resident #51 was admitted to the facility on [DATE] with diagnoses that included Acute and Chronic Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease with Acute Exacerbation, and Pneumonia. A Brief Interview for Mental Status (BIMS) was done on the Admission Minimum Data Set with an assessment reference date of 03/19/25. The BIMS score was 15 which indicated the resident had intact cognition. On 04/07/25 at 9:36 AM an interview was conducted with Resident #51. The resident stated he was given potato chips for supper last night (04/06/25) and a couple of sides but the main dish was chips. He further stated he was a vegetarian and thinks the kitchen does not know what to give him. On 04/07/25 at 12:05 PM an observation of the lunch meal revealed the resident was given fruit and cottage cheese. Record review revealed the resident was on a Regular diet, Regular texture, Regular/Thin Liquids consistency. A review of the resident's meal ticket for 04/06/25 for dinner revealed cottage cheese and fruit plate, 1/2 cup of potato wedges, 1/2 cup of coleslaw, a dinner roll, 8 ounces of milk, 6 ounces of tea of choice and a chocolate chip cookie. Review of the resident's meal ticket for breakfast on 04/09/25 revealed 1 biscuit, 6 ounces of hot cereal, 8 ounces of milk, 6 ounces of coffee or hot tea and 4 ounces of apple or cranberry juice. Review of the resident's meal ticket for lunch on 04/09/25 revealed a cottage cheese and fruit plate, 1/2 cup of parsley noodles, 1/2 cup of honey roasted carrots, 1 dinner roll, 1 slice of brown sugar glazed angel food cake and 6 ounces of tea. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's meal ticket for dinner on 04/09/25 revealed cottage cheese and fruit plate, 1/2 cup tater tots, 1/2 cup braised cabbage, 1 dinner roll, 8 ounces of milk, 6 ounces of tea and 1/2 cup of sliced pears. A review of the resident's food preference assessment did not indicate that he was vegetarian. A review of the resident's nutrition assessment form dated 03/19/25 did not reveal he was vegetarian. On 04/10/25 at 11:00 AM an interview was conducted with Staff E, a registered dietitian. Staff E was asked if he was aware that Resident #51 was a vegetarian. He stated he was not aware. He then stated he would make sure his protein needs were met. The surveyor and Staff E then went to Resident #51's room together to interview him. The resident stated he had been a vegetarian since the 1970's. He likes rice, beans and fish. He is enjoying the cottage cheese, yogurt and fruit that is being provided for lunch and dinner but would also like a little variety. He stated last Sunday night he was provided a plate of potato chips for dinner and he was so hungry he ate them all. Staff E stated he would add fish to his diet and bean patties and veggie burgers. The resident was pleased. On 04/10/25 at 2:20 PM an interview was conducted with the kitchen manager who stated there is no diet for Lacto-ovo-vegetarian but she knew his preferences. They do preferences every 3 months of all of the residents but she had been to see him three times already for his preferences. The surveyor informed the kitchen manager that the dietitian was not aware that the resident was a vegetarian until surveyor intervention. 51137 2. Review of the record revealed Resident #16 was admitted on [DATE] with the admitting diagnosis of Intervertebral Disc Displacement, Lumbar Region (a condition where the discs in the lower back push through the tougher outer ring.) Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #16 had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. Review of the current orders revealed Resident #16 had a Carbohydrate Controlled Diet (CCD) with No Added Salt (NAS), (a dietary approach that focuses on managing carbohydrate intake and limiting sodium.) During an interview on 04/07/25 at 11:12 AM, when asked how the food was, he stated all his food was overcooked and burnt all the time. He described the servings of chicken as stringy and dry. Resident #16 showed the surveyor several pictures of the meals he was upset about. The food is often not edible, I ask myself; how can you send food out of the kitchen that looks like this, Resident #16 stated. When asked If he had told anyone about the concerns, he stated that he had addressed this with the Certified Dietary Manager, (CDM) but they were never fixed. The Resident stated Sunday night he was only served potato chips as an entree, photographic evidence obtained. He voiced he does not eat pork due to religious reasons and the main entree included a pork product that night. The Resident was not given an alternative entree option, leaving him without protein for dinner. Resident #16 was visibly upset during the interview, The food is unacceptable, he stated. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a dining observation on 04/07/25 at 1:06 PM, when asked how lunch was, Resident #16 stated his chicken was moist and cooked right; the Resident compared his meal to restaurant style quality. This is the first time in over a year it is cooked right, its only because you guys are here. Resident #16 stated that it usually never tasted that good and it was upsetting to him because it shows how much potential the kitchen had to put out a good meal. During a follow up dining observation on 04/08/25 at 1:25 PM, when asked how lunch was, Resident #16 stated he had quiche and a bread roll for lunch. I ate the bread because I was still hungry, he voiced. The Resident stated he couldn't eat the brussels sprouts on his meal tray because they were burnt, (photographic evidence obtained.) He stated, How can someone send out food that looks like this. During an interview on 04/10/25 at 09:03 AM, when asked if she was aware of Resident #16's food concerns, the CDM stated the Resident was at the last resident council meeting and he had spoke to her regarding his concerns of burnt food and she had addressed it at that moment. The CDM was shown pictures of Resident #16's meals he was upset about including the picture of the Resident's meal tray with only potato chips as an entree, the CDM acknowledged the findings. She stated that he should have been given another alternative that did not include pork but the meal ticket system did not capture that. During an interview with Resident #16 and the CDM on 04/10/25 at 09:57 AM, the CDM stated to the Resident We talked the last time you came to resident council meeting and had concerns about the food being burnt, have you seen any kind of improvement since? Resident #16 replied, No, it is getting worse. The cooks are putting out food that is poor quality; most of the time the food is not edible. The chicken is so dry and stringy; the noodles are rubbery; some food comes out so greasy and mostly everything else is always burnt. The Resident told the CDM that Monday's lunch was restaurant quality and it was upsetting to him because it showed him the potential the kitchen had to put out a good meal. Resident #16 addressed Sunday night's dinner that included only potato chips as an entree, the CDM acknowledged his concerns and stated he should not have only been provided potato chips. She stated the Resident should have received an alternative entree that did not include pork but the meal ticket system did not capture that. The CDM apologized to the Resident for all the concerns he had experienced.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51137 Based on interview and record review, the facility failed to provide restorative therapy as recommended by the Director of Physical Therapy for 2 of 2 sampled residents (Resident #62, and Resident #104.) The findings included: 1. Review of the record revealed Resident #62 was initially admitted on [DATE] with the admitting diagnosis of Paraplegia (the inability to voluntarily move the lower parts of the body.) Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #62 had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. During an interview on 04/07/25 at 10:23 AM, when asked if he received any kind of therapy, Resident #62 stated he wasn't sure what kind of therapy he received but was pretty sure it was called restorative therapy. When asked how often he received it, he stated it wasn't that often because they don't have a lot of staff available to provide it; but when he received it, it helped. Review of the current orders did not reveal any kind of active therapy orders. During an interview on 04/09/25 at 2:05 PM, when asked if he knew what therapy orders Resident #62 had receivied, the Director of Physical Therapy stated he wasn't sure at the moment and would find out. During a follow up interview on 04/09/25 at 3:53 PM, the Director of Physical therapy, provided the surveyor a document titled Therapy Communication to Restorative Nursing Program (RNP) indicating the resident was part of the program. This document included Resident #62's functional status; problems/needs; and recommendations/approaches, photographic evidence obtained. When asked why there were no orders and what was done to keep track of when it was provided to the Resident, he stated that he was not sure how they kept track of it and that the Director of Nursing (DON) should be asked instead. During an interview on 04/09/25 at 4:24 PM, why Resident #62 did not have a RNP order, the DON stated the facility did not currently have a RNP since they only had one Restorative Certified Nursing Assistant (CNA), Staff C. The DON stated in order to have a program they would need a restorative nurse or an additional restorative CNA. When asked how many Residents were part of the RNP, the DON replied 10-15 residents. When asked how they kept track of what services were being provided to the Residents, the DON stated it should be documented in the electronic medical record. When the DON was made aware there was no documentation of Resident #62'S RNP services, she stated Staff C is supposed to be documenting in the electronic medical record but is aware she isn't documenting. She agreed on the importance of documenting work completed and that it should have been documented. It's a work in progress. she stated. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/25 at 09:29 AM, when asked to described Resident #62's RNP, Staff C stated, Leg exercises, all lower body, his upper body is okay. When asked how often he received the RNP and the last time he received it, she replied 3 times a week and Tuesday was the last time he received it, he would receive it later on that day. When asked how the dates are determined for the RNP days she stated she would pick the days she usually worked (Tuesday, Thursday, and Saturday.) Staff C provided the surveyor a list titled Restorative Nursing Program indicating all the current residents that were part of the program. Review of the list revealed 29 residents had current RNP recommendations, the most recent recommendation was on 03/28/25. During a side-by- side review of the list, Staff C was asked how she had time to see everyone, I try but it's hard, sometimes I have to spend less time with them. When asked to provide documentation of Resident #62's RNP services, Staff C stated she had not been documenting it. When asked why she hadn't been documenting, Staff C stated they had not set her up with a kiosk (computer CNAs document in) so she had not been able to put her documentation on it. They told me they would set one up for me but still haven't she stated. When asked if she wrote down what she did by hand, Staff C stated No, I don't write it down; I just keep it in my head and go from room to room. When asked if there was a reason she hadn't documented her work, she stated No, I'm just used to looking at my paper and doing it. She agreed that she should be documenting the work she is performing for the residents. 39026 2. Resident #104 was admitted to the facility on [DATE] with diagnoses that included Cerebral Infarction and Atrial Fibrillation. His Brief Interview for Mental Status (BIMS) score was 14 on the quarterly Minimum Data Set (MDS) with an assessment reference date of 03/08/25. This indicated the resident had intact cognition. Section O of this assessment revealed the resident had no restorative therapy minutes. On 04/07/25 at 10:19 AM an interview was conducted with Resident #104. The resident stated he was cut off by physical therapy because of documentation. He is only getting restorative some of the time. An interview was conducted with the Director of Nurses on 04/09/25 at 4:24 PM regarding the restorative program. She stated they don't currently have a restorative program in place ; to have a program they need two restorative aides and they currently only have Staff C available who works 3 times a week and provides these services to the residents when she works. They used to have a restorative program in the past. On 04/10/25 at 9:29 AM an interview was conducted with Staff C, identified as the restorative aide. She stated she had 29 residents on restorative therapy but has no documentation on the residents. She is the only one who does restorative. On 04/10/25 at 12:46 PM an interview was conducted with the Director of Physical Therapy regarding Resident #104. The Director stated the resident was discharged from therapy because of insurance coverage. He appealed and he was denied. Therefore, he referred him to restorative on 01/28/25 for 3 times a week restorative therapy. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Discussed with Director of Physical Therapy why is he referring residents to restorative when he is aware that the facility does not have a restorative program. He stated that they are working on it.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51137 Based on observation, interview, and record review the facility failed to accurately document narcotic administration for 2 of 6 residents reviewed (Resident #79 and Resident #377). The findings included: 1. Review of the record revealed Resident #377 was admitted on [DATE] with a diagnosis of Encephalopathy (a condition where there is brain disease, damage or malfunction). Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #377 had a Brief Interview for Mental Status (BIMS) score of 11, on a 0 to 15 scale, indicating the Resident had moderate cognitive impairment. Review of the current orders revealed Resident #377 had an active order for Lorazepam 0.5mg tablet one tablet by mouth every 8 hours as needed. 2. Review of the record revealed Resident #79 had an initial admission of 04/04/23 and re-entry on 08/15/24 with a primary diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side (a condition where there is paralysis and muscle weakness on one side of the body). Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #79 had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. Review of the current orders revealed Resident #79 had an active order for Lacosamide 100mg tablet, one tablet by mouth twice daily for seizures. 3. During a medication storage observation on 04/09/25 at 12:30 PM, the medication cart for the 200 unit was checked with Staff H, Licensed Practice Nurse (LPN). The paper documentation form titled Medical Monitoring/Control Record (MMCR) was compared with the electronic Medication Administration Record (MAR) for Resident #79 and Resident #377, who were both receiving narcotics. There were discrepancies for both Residents. The documentation on the MMCR revealed that the Lorazepam for Resident #377 was administered on 04/01/25 at 9:55 AM but was not documented on the MAR. On 04/04/25, this same medication was logged in the MMCR at 20:30 and documented on the MAR at 21:04. The documentation on the MMCR revealed that the medication Lacosamide for Resident #79 was administered three times on 04/06/25 as follows: 9:09 AM, 10:13 AM, and 6:04 PM. and one time on 04/07/25 at 5:30 PM. Review of the MAR computerized documentation revealed two administrations of the medication Lacosamide on 04/06/25 and one administration on 04/07/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 04/09/25 at 12:36 PM, with the Director of Nursing (DON). When asked for clarification on the narcotic discrepancy found for Resident #79, the DON reviewed the MAR and the MMCR for Lacosamide. She stated, The medication cannot be given three times due to it being a scheduled medication. The computer will not let her (the nurse). This has to be a mistake. The DON agreed that the documentation on the MMCR did not match what was documented in the MAR. The DON agreed it should have been documented accurately. When made aware of the 2 discrepancies regarding the Lorazepam documentation for Resident #377, she agreed to the findings and stated she would find the nurse to interview. During an interview on 04/09/25 at 12:56 PM an interview with Staff D, Registered Nurse (RN), the nurse who administered Lorazepam for Resident #377. When asked about the discrepancy, Staff D stated, I made a mistake on the documentation of the date, I wrote 04/01/25 but it was supposed to be 04/02/25. When asked about the time discrepancies on 04/04/25 between the MMCR and the MAR, she admitted the times were off and should have been the same. During a phone interview on 04/09/25 at 1:06 PM, when asked about the medication administration for Lacosamide for Resident #79 on 04/06/25, Staff B, Registered Nurse (RN) stated, I made a mistake on the date I documented on the paper narcotic log. I did not work on 04/06/25, it was suppose to be 04/07/25. The DON who was present for both nurse interviews agreed that the staff should know the importance of documenting accurately especially when it came to narcotics.

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	04/10/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 39026 Based on observations, interviews and policy review, the facility failed to maintain a dryer drum in a sanitary manner for 1 of 3 dryers observed in the laundry room, failed to provide a gown for sorting in the sorting area of the laundry room, failed to keep a broom and pan off of the floor in the laundry room; and failed to properly clean and disinfect a glucometer per facility policy. The findings included: 1. The facility's policy titled Cleaning and Disinfection the Meter with no date, revealed to disinfect: open the towelette container and pull out 1 towelette and close the lid. Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using 1 towelette to clean blood and other body fluids. Carefully wipe around the test strip port by inverting the meter so that the test strip port is facing down. This prevents disinfectant liquid from entering the meter. Properly dispose of the used towelette. Treated surface must remain wet for recommended contact time .do not wrap the meter in a wipe. Once contact time is complete, wipe meter dry. On 04/08/25 at 11:19 AM Staff A, a registered nurse, performed an accucheck on Resident # 109. The blood sugar was taken and no insulin coverage was necessary. After the accucheck was completed, Staff A returned to her medication cart to put away her supplies and clean and disinfect the glucometer. She took one Clorox wipe out of the container and wrapped the glucometer with the wipe. She did not wipe the entire surface of the glucometer horizontally and vertically. She stated she would let the glucometer sit wrapped for 3 minutes. When questioned, she said she will wipe it down after she let it sit for 3 minutes. Discussed with Director of Nurses and regional nurse consultant on 04/08/25 at 1:00 PM who agreed that the glucometer was not cleaned and disinfected properly. 2. An observation of the laundry room was conducted with the Director of Housekeeping on 04/10/25 at 9:29 AM. Walking into the dirty area of the laundry an observation was made of a broom with a pan on the floor. There was no gown for sorting in the dirty area. There are 3 washing machines. There are 3 dryers but 2 are working. Dryer #1 was observed with dry, hard residue stuck on the drum (photographic evidence obtained). An interview was conducted with the Director of Housekeeping who stated it is an old dryer and we want to get a new drum.

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	04/10/2025

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

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interview, and record review, the facility failed to provide a pneumococcal vaccination to a resident who consented to receive the pneumococcal immunization for 1 of 5 residents sampled for immunizations (Resident #32). The findings included: Resident #32 was admitted to the facility on [DATE] with diagnoses that included Dementia, Congestive Heart Failure, and Type 2 Diabetes Mellitus. His Brief Interview for Mental Status (BIMS) score was 2 on the quarterly minimum data set with an assessment reference date of 02/23/25. This indicated the resident had severe cognitive impairment. On 04/09/25 at 4:00 PM an interview was conducted with the Infection Preventionist and the Director of Nurses (DON). A record review was conducted of 5 residents for receiving flu and pneumonia vaccines. A consent to receive a pneumonia vaccine was signed on 09/05/24 for Resident #32. There was no record in the electronic health record (EHR) that this vaccine was administered. The DON and Infection Preventionist stated they would look to see if there was any documentation that it was given that was not entered into the EHR. Discussed with DON on 4/10/25 at 9:15 AM who said she would look into this further and provide further information if she could find it. On 04/10/25 at 2:40 PM the DON provided the surveyor with a new consent for the pneumonia vaccine dated 04/10/25 for Resident #32. She stated the vaccine was ordered and was given today. The DON acknowledged it was not given after the last consent was done.