STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on observation, interview and record review, the facility failed to treat residents who required assistance with meals in a dignified and respectful manner for 4 of 4 residents reviewed for dining, of a total sample of 17 residents, (#4, #15, #16, and #17). Findings: 1. Review of resident #4's medical record revealed she was admitted to the facility on [DATE] with diagnoses including multiple sclerosis and aphasia. Review of resident #4's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 6/13/24 revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating severely impaired cognition. She was totally dependent on staff for bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. On 6/19/24 at 8:25 AM, resident #4 sat in bed while Certified Nursing Assistant (CNA) H assisted her with breakfast. CNA H fed resident #4 while standing next to her bed. CNA H then sat down and stated someone else was coming to feed resident #4's roommate. CNA H said, We have a lot of feeders. 2. Review of resident #15's medical record revealed he was admitted to the facility on [DATE] with diagnoses of Parkinson's disease, congestive health failure, type 2 diabetes and glaucoma. Review of resident #15's quarterly MDS assessment with ARD of 3/25/24 revealed a BIMS score of 10 out of 15, indicating moderately impaired cognition. He required substantial assistance with Activities of Daily Living (ADLs), including eating. On 6/18/24 at 12:30 PM, CNA G was observed feeding resident #15 while standing. 3. Review of resident #16's medical record revealed he was readmitted to the facility on [DATE] with diagnoses of stroke and dementia. Review of the quarterly MDS assessment with ARD of 6/04/24 revealed a BIMS score of 0 out of 15, indicating severely impaired cognition. He was totally dependent on staff for eating. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/18/24 at 12:35 PM, resident #16 was lying in bed with his lunch tray at the bedside table. CNA F entered his room a couple of minutes later, elevated the head of the bed and began to feed resident #16 while standing next to him. At 12:40 PM, CNA F assisted resident #16 with a drink while still standing by his bed. 4. Review of resident #17's medical record revealed she was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, Parkinsonism, and type 2 diabetes. Review of resident #17's annual MDS assessment with ARD of 5/11/24 revealed a BIMS score of 0 out of 15, indicating severely impaired cognition. She was totally dependent on staff for all ADLs, including eating. On 6/18/24 at approximately 12:40 PM, CNA G was observed feeding resident #17 while standing next to her and not talking to the resident. On 6/18/24 at 12:50 PM, CNA F acknowledged she had stood while feeding resident #16. She indicated even if his bed was in the lowest position she was unable to reach him. She indicated she knew she was not supposed to stand when feeding the resident because it could give the impression she was rushing him. She mentioned when he was in bed, she remained standing to feed him. She stated she had not mentioned to the nurse or the Unit Manager (UM) she stood to feed him because she was too short. She then stated on CNA G's assignment there were, 3 feeders. On 6/18/24 at 1:24 PM, CNA G stated her assignment included 5 residents who required assistance with meals. She indicated she sometimes sat but usually stood up when feeding residents. She said, I know I am supposed to sit. She acknowledged there was a chair in resident #15's room. She validated she stood when feeding resident #17. She mentioned she was supposed to be at eye level, make the resident comfortable, and talk to the resident while feeding him or her. On 6/19/24 at 11:49 AM, CNA H stated resident #4's bed did not go all the way down for her to be in a comfortable position to feed the resident. She stated she had not told the UM or anyone about it. She indicated she sat down after giving resident #4 the first bite. She validated she referred to residents as feeders earlier but should have not used that word in reference to them. On 6/20/24 at 4:27 PM, the Administrator and Director of Nursing validated the CNAs were expected to sit while feeding residents and should not refer to residents as feeders. The Regional Nurse Consultant stated CNAs had been educated many times about this. She said it was a matter of, diligently micromanaging the full house. Review of the Skills Competency Assessment: Eating Support required for all CNA staff revealed the employee was evaluated to perform tasks listed independently and without supervision. The skills and competency included, Never make the resident feel that the meal must be hurried but the procedure is pleasant. Give him/her your complete attention. Sit so you are at the same level as the resident. Review of the facility policy and procedure titled Resident Rights dated 11/30/14 read, It is the policy of The Company to . Ensure that residents' rights are known to staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on record review and interview, the facility neglected to provide appropriate care and services to prevent a pressure injury for a vulnerable and physically impaired resident and failed to complete a thorough investigation for neglect after a worsening pressure injury for 1of 4 residents sampled for pressure ulcers, of a total sample of 17 residents, (#3). The facility's failure to implement preventative interventions, ensure timely and adequate treatments for pressure injuries and complete a thorough investigation for neglect resulted in actual harm, for one dependent resident who was deemed at risk for development of wounds. Resident #3 acquired a pressure injury in the facility that was not treated for 10 days after it was identified which caused the wound to worsen. Resident #3 suffered severe wound infections and sepsis that required hospitalization . He later died on hospice services. Findings: Resident #3 was an [AGE] year-old male, admitted to the facility on [DATE] with diagnoses that included lung abscess with pneumonia, Alzheimer's disease, anxiety, type 2 diabetes, prostate cancer, cognitive communication deficit, and urinary retention. The medical record indicated resident #3's skin was intact when he was admitted to the facility. Resident #3 was discharged to an acute care hospital on [DATE]. Review of the Minimum Data Set (MDS) Discharge, Return Anticipated assessment with assessment reference date of [DATE] revealed resident #3 had severely impaired cognitive skills for daily decision-making. The document indicated he did not exhibit any behavioral symptoms or reject evaluation or care necessary to achieve his goals for health and well-being. The assessment revealed the resident required moderate to maximum assistance with activities of daily living (ADL) and moderate assistance to roll side to side and sit up in bed. Section H of the assessment indicated he was always incontinent of bowel movements. The MDS assessment revealed resident #3 had one unhealed Stage III pressure ulcer not present on admission to the facility. In an interview on [DATE] at 9:05 AM, the MDS Coordinator clarified resident #3 actually had a stage IV pressure ulcer upon his discharge from the facility. A Change in Condition dated [DATE] documented the resident was observed with an open area on the right buttock. The note indicated the physician gave orders for nursing staff to follow up with the wound care team. A progress note dated [DATE] at 7:51 PM, read the resident was observed with an open area on the right buttocks and the wound care team was consulted. The note indicated the primary care physician was notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record revealed resident #3 did not receive treatment for the open wound for another 10 days, until [DATE]. Additionally, the record reflected resident #3 had no documentation that treatments were completed for 8 of the 18 days in which he had orders for daily treatments to the wound in the Treatment Administration Record. Almost half of his wound treatments were not documented as completed from [DATE] through [DATE]. On [DATE] at 5:44 PM, Certified Nursing Assistant (CNA) B recalled resident #3 as confused but he pleasant and friendly. She remembered she tried to keep him on his side but when she didn't have him on her assignment, he would always be on his back unless he was in the chair. She indicated she even talked to the night shift staff to try to keep him off his back because it went from a tiny little area to a bigger area in three days while she was off. The family spent a long time here and were concerned about his wound. On [DATE] at 12:20 PM, Registered Nurse (RN) E stated CNA B notified her resident #3 had a wound. She recalled she then informed the wound care nurse, and the Advance Practice Registered Nurse (APRN). RN E remembered he had no wounds on his bottom,then she was off a few days and when she came back he had the open wound there. She said, He did not have an air mattress on the bed when the wound was discovered. She stated he had poor nutrition which could affect his skin or a wound. She said his wife was at his bedside when the wound was discovered. On [DATE] at 3:50 PM, the Administrator, Director of Nursing (DON), and the Regional Nurse Consultant (RNC) reviewed notes from the Quality Assurance Performance Improvement (QAPI) meeting held on [DATE]. They indicated the discussion included skin checks and dressing changes. The DON stated a facility wide audit was conducted to ensure all residents had an up-to-date skin assessment and wound dressing changes. The plan was to educate 100% of nurses, educate the Interdisciplinary Team (IDT) and Unit Managers. The DON/designee would complete 5 random audits 5 times a week for 4 weeks, then weekly for 4 weeks, then monthly for 2 months. A Performance Improvement Plan (PIP) was initiated on [DATE] regarding pressure wounds. The DON stated they did additional education regarding documentation and expectations for the nurses. For CNAs the education included the expectation to look at the resident's skin each time care was provided and notify nurses of changes they observed. The DON explained the facility did audits to ensure dressings were changed and documentation supported the change as well. She added an ad hoc QAPI meeting was held and a PIP was developed and implemented for pressure wounds. The DON was unable to say why resident #3 was not included in the PIP or on any audits for pressure wounds. The RNC stated they revised the PIP on [DATE] and were still working on it. The Administrator stated that on [DATE], the facility was informed by the Department of Children and Families (DCF) there was an allegation of neglect. Review of the investigation regarding the neglect complaint for Resident #3 included the following information: On [DATE], the Administrator interviewed the Wound Care nurse. She stated she last saw resident #3 with the wound care physician on [DATE]. She stated he had a stage IV sacral wound and the current treatment in place was a calcium alginate dressing with moistened gauze with Dakins solution. She further stated the treatments were being following according to the physician orders. The wound was determined to be stable at that time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 0600 Level of Harm - Actual harm Residents Affected - Few	On [DATE], the Rehabilitation Director was interviewed by the Administrator. He stated resident #3 received physical, occupational and speech therapy while in the facility. However, in spite of rehabilitation interventions, he did not demonstrate significant functional progress, attributable to the effect of multiple comorbidities. He stated the resident was not ambulating upon admission to the facility. He further stated that aggressive rehabilitation to achieve ambulation was neither practical, safe or appropriate, so it was not implemented. He said, a head-to-toe skin assessment was completed by the DON on [DATE]. No new skin impairments were identified. The Administrator said the investigation found that review of the medical record revealed resident #3 was evaluated by the wound care physician on [DATE], 13 days after the wound was identified by CNA B and the primary care physician verbally ordered a wound consult. A wound debridement was performed on the sacral wound at that time and new orders were given for a calcium alginate dressing. The next week on [DATE], the resident was again reevaluated by the wound care physician and noted the wound continued to decline. No new treatments were ordered at that time. On [DATE], the resident was seen by the primary care physician and new orders were given for antibiotics for a suspected urinary infection. On [DATE], the resident was seen by the wound care physician and the wound was noted to be stable. The wound care physician discussed hospice services with the family at bedside. On [DATE], the resident was seen by the physician and the daughter was at bedside and requested the resident be transferred to the hospital for urinary catheter exchange and wound care. The physician expressed the resident did not need to be transferred because he was currently being treated but the daughter insisted the patient transfer to the hospital. He said the allegation was refuted by evidence collected during the investigation. Based on interviews from facility staff members and residents, it was unable to be determined that the allegation of neglect occurred the Administrator said. On [DATE] at 3:50 PM, the DON stated the revised PIP included looking at physician orders for treatment, review of the care plan, physically checking the resident, and documentation to support that everything was done. The investigation read that no new orders were given but review of resident #3's medical record revealed new orders for treatment were given every week when the wound care physician saw him. The investigation revealed only the wound nurse and Director of Rehabilitation were interviewed as to the neglect concerns. There were no interviews with the assigned nurses or CNAs who took care of the resident regarding his wound or the care given. The DON stated the wound nurse did not attend the ad hoc meeting on [DATE]. She was not able to explain why the wound nurse was not in attendance. On [DATE] at approximately 4:15 PM, the NHA acknowledged not providing wound care for resident #3 was neglect. She also acknowledged a thorough investigation and review of resident #3's chart was not conducted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on observation, interview, and record review, the facility failed to review or revise the individualized pressure ulcer plan of care for 1 out of 4 residents reviewed for pressure ulcers, (#3) and failed to develop and implement an individualized comprehensive care plan for a resident reviewed for care planning, (#4), of a total sample of 17 residents. Findings: 1. Resident #3 was an [AGE] year-old male, admitted to the facility on [DATE] with diagnoses to include abscess of lung with pneumonia, Alzheimer's disease, anxiety, type 2 diabetes, prostate cancer, difficulty walking, cognitive communication deficit, and urinary retention. The medical record indicated resident #3's skin was intact when he was admitted to the facility. The record indicated resident #3 was discharged to an acute care hospital on 5/08/24. Review of the Minimum Data Set (MDS) Discharge Return Anticipated assessment with assessment reference date of 5/08/24 revealed resident #3 had severely impaired cognitive skills for daily decision-making. The document indicated he did not exhibit any behavioral symptoms or reject evaluation or care necessary to achieve his goals for health and well-being. The assessment revealed the resident required moderate to maximum assistance with activities of daily living and moderate assistance to roll side to side and sit up in bed. Section H revealed he was always incontinent of bowel movements. The MDS assessment revealed resident #3 had one unhealed Stage III pressure ulcer not present on admission to the facility. In an interview on 6/19/24 at 9:05 AM, the MDS Coordinator clarified resident #3 actually had a stage IV pressure ulcer upon his discharge from the facility. Review of the comprehensive care plan dated 4/04/24 included focus items for a potential for pressure injury. Review of the medical record revealed the resident was found to have an actual pressure injury on 4/10/24. Review of the medical record revealed this pressure injury progressed from a stage II to a stage IV over the 27 days between 4/10/24 and 5/07/24. The care plan was never updated to reflect resident #3's actual pressure injury or any new or correlating interventions. All interventions listed were for prevention of a pressure injury. On 6/19/24 at 9:05 AM, the MDS Coordinator stated resident #3's new wound should have triggered a change in condition, which would have been discussed in morning meeting. She explained a new care plan should have been developed at that time. She confirmed resident #3 did not have a care plan for an actual pressure ulcer, nor any individualized interventions. She said the wound should have triggered a significant change. The MDS Coordinator could not explain why a care plan for resident #3's worsening pressure wound was not in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Plan of Care policy effective date 11/30/14 and revised 9/25/17 described an individualized person-centered plan of care would be established by the interdisciplinary team with the resident and/or resident representatives to the extent practicable and updated in accordance with state and federal regulatory requirements. The policy further detailed the comprehensive care plan should be reviewed, updated and/or revised based on changing goals, references and the needs of the resident in response to current interventions. It indicated the interdisciplinary team should ensure the plan of care addressed resident needs and was oriented toward attaining or maintaining the highest practicable physical, mental and psychological well-being. 43192 2. Review of resident #4's medical record revealed she was admitted to the facility on [DATE] with diagnoses including multiple sclerosis and aphasia. Review of resident #4's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 6/13/24 revealed a Brief Interview for Mental Status score of 7 out of 15, indicating severely impaired cognition. She was totally dependent on staff for activities of daily living. The annual MDS assessment with ARD of 3/13/24 revealed it was very important to have family or close friends involved in discussions about her care. On 6/18/24 at 5:21 PM, resident #4 was observed in bed with her eyes closed, and the television on. A letter in a plastic sleeve was noted on the bedside table with instructions for dinner time which included to give ginger ale and use the straw located next to the note. Another note instructed staff not to ever give water or ice from the facility, but the family provided it instead. Review of resident #4's comprehensive care plan included Advanced Directives revised on 5/29/24, communication problem revised on 5/25/23 and dependence on staff for meeting emotional, intellectual, physical and social needs revised on 4/29/23. The care plan did not address resident #4's personal choices and individual needs and preferences identified through care conferences and interdisciplinary team (IDT) meetings. Review of the Care Conference Record form revealed resident #4's sister and responsible party attended the following care conference meetings: 4/25/23, 5/25/23, 7/25/23 and 10/12/23. On 6/18/24 at 1:24 PM, Certified Nursing Assistant (CNA) G stated every time she helped resident #4 it took 45 minutes to an hour because her family had a list of specific tasks to be performed for the resident. She explained the list was not included in the care plan, but she had seen the notes in the room. On 6/18/24 at 2:11 PM, Licensed Practical Nurse (LPN) E stated resident #4's family had posted signs for them to read and follow to meet her needs. She indicated resident #4's sister's preferences included using bottled water provided by them and not to use ice from the facility. She mentioned there were signs for everything: lights, volume, TV on, socks on, use of certain pillows. She confirmed those preferences were not listed in the care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/24 at 11:49 AM, CNA H stated resident #4's sister prepared notes with instructions for care. She shared resident #4's family provided their own chair, sheets, pillowcases, and personal care items. She stated CNAs could refer to the Kardex (plan of care) when they had questions about the care for a resident but did not recall if specific requests from resident #4's family were included there. On 6/19/24 at 8:52 AM, the MDS Coordinator explained her responsibilities included scheduling care plan meetings and creating and updating the residents' care plans. She indicated the care plan was closed the day the care plan meeting was held. She stated the purpose of the care plan was to ensure they complied with the residents' care needs and preferences. She shared the nurses and CNAs referred to the care plan to guide the care they provided. She indicated she included any preferences a resident or his/her representative had. She shared when resident #4's sister attended the care plan meetings she expressed concerns to the IDT, which included the Director of Nursing (DON) and the Administrator (NHA). The MDS Coordinator indicated she was aware resident #4 had a bowel regime and there were specific requests about positioning when in the wheelchair. She stated resident #4's sister preferred to include instructions for her care at the bedside table, on the wall, and inside a drawer. The MDS Coordinator reviewed resident #4's care plan, and asked herself, Where did I put it? when asked if she included the requests and preferences communicated to them. She validated it would have been important to include the information in the care plan for all staff to access. On 6/19/24 at 12:35 PM, the Social Services Assistant explained she was the Social Services Director (SSD) until January 2024. She indicated she attended care plan meetings when she was the SSD and was familiar with resident #4 and her family. She shared resident #4 had strong family relations and her sister was the main caregiver for over [AGE] years. She explained when resident #4 first moved in, her sister had a notebook with about 50 things written on how to take care of her. She stated the IDT discussed her care constantly. She indicated resident #4's sister had shown frustration regarding some care concerns. The Social Services Assistant stated she created a care plan for a mood problem and sad affect on 4/14/23 but did not create one related to the family's requests because things were smooth at that time and was mostly difficult adjustment for resident #4's sister. She mentioned resident #4's sister no longer attended care plan meetings maybe out of frustration, why bother if nothing improves or changes. She shared resident #4's sister had a binder with several pages of instructions for caring for her sister. She recalled the sister expressed preferences such as which outfits to be worn each day. She explained the care plan was created to inform staff how to care for the resident and contained helpful information for the staff to know. On 6/20/24 at 5:00 PM, the NHA stated resident #4's sister had a binder, and agreed no information was mentioned about the binder or their preferences in the care plan. The facility's policy and procedure titled Plans of Care revised on 9/25/17 read, Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident . The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental, and psychological well-being. The policy revealed the plan of care may include, Individualized interventions that honor the resident's preference and promote achievement of the resident's goals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on observation, interview, and record review, the facility failed to provide care and services, according to professional standards of practice, to promote skin integrity and prevent the development and worsening of pressure injuries for 1 of 4 residents reviewed for pressure injuries, of a total sample of 17 residents, (#3). The facility's failure to implement preventative interventions and ensure timely and adequate care and treatments for pressure injuries resulted in actual harm, for one dependent resident who was deemed at risk for development of wounds. Resident #3 acquired a pressure injury that was not treated for 10 days after it was identified which caused the wound to worsen. Resident #3 suffered severe wound infections and sepsis that required hospitalization , and he subsequently died on hospice services. Findings: Review of the medical record revealed the resident was an [AGE] year-old male, admitted to the facility on [DATE] with diagnoses to include lung abscess with pneumonia, Alzheimer's disease, anxiety, type 2 diabetes, difficulty walking, cognitive communication deficit, urinary retention. The medical record indicated resident #3's skin was intact when he was admitted to the facility. The record indicated resident #3 was discharged to an acute care hospital on [DATE]. John Hopkins Medicine defines pressure injuries, also called bed sores or pressure sores as follows: Pressure injuries are most likely to occur in older adults, particularly those who live in nursing homes. Studies show more than 1 in 10 nursing home residents have suffered from a bedsore. Those with chronic illnesses like diabetes and those who are under nourished are at greater risk . If found and treated quickly, pressure injures should heal within a matter of weeks. But if left untreated, they can quickly worsen. Pressure injuries start as red, blue, or purplish patches on the body. The don't blanch, or turn white, when touched and they get worse over time. These patches can quickly develop into blisters and open sores. The sores can then become infected and grow deeper until they reach muscle, bone or joints. Pressure injuries have 4 stages, ranging from an early warning signal to the most severe: Stage I. Red, blue or purplish area first appears on the skin like a bruise. It may feel warm to the touch and burn or itch. Stage II. The bruise becomes an open sore that looks like an abrasion or blister. The skin around the wound can be discolored and the area is painful. Stage III. The sore deepens and looks like a crater, often with dark patches of skin around the edges. Stage IV. The damage extends to the muscle, bone, joints and can cause a serious infection of the bone, known as osteomyelitis. It can also lead to a potentially life-threatening infection of the blood called sepsis, (retrieved on [DATE] from www.hopkins medicine.org). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) Discharge Return Anticipated assessment with assessment reference date of [DATE] revealed resident #3 had severely impaired cognitive skills for daily decision-making. The assessment indicated he did not exhibit any behavioral symptoms or reject evaluation or care necessary to achieve his goals for health and well-being. The assessment also revealed the resident required moderate to maximum assistance with activities of daily living (ADL), moderate assistance to roll side to side and sit up in bed and maximum assistance to sit up to stand and transfer to a chair. Section H of the assessment indicated he was always incontinent of bowel movements. The MDS assessment revealed resident #3 had one unhealed Stage III pressure ulcer not present on admission to the facility. In an interview on [DATE] at 9:05 AM, the MDS Coordinator clarified resident #3 actually had a stage IV pressure ulcer upon his discharge from the facility. On [DATE] at 9:12 AM, resident #3's daughter stated when she saw how bad the pressure sore looked, she talked to everyone at the facility. She said, They were supposed to change him and reposition him every few hours, but I was there for over 7 hours, and no one changed him or repositioned him the whole time. She explained he had a urinary catheter, and it was never changed at the nursing home although it was supposed to be changed every month. She stated the resident was discharged from the hospital on [DATE] to short-term rehabilitation to complete intravenous antibiotic therapy. She said her father was put in hospice two weeks after entering the nursing home and passed away two weeks later. Review of the medical record revealed a care plan dated [DATE], for bowel incontinence related to immobility. The goal was for the resident not to have skin breakdown related to incontinence. Interventions included staff to provide incontinence care after each incontinent episode. Another care plan dated [DATE], revealed the resident had potential for pressure injury development related to decreased mobility and incontinence. The goal was for the resident to have intact skin, free of redness, blisters or discoloration by/through the review date. Interventions included staff to follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor nutritional status, serve diet as ordered, and monitor/ document/report any changes in skin status. An additional care plan also dated [DATE] revealed the resident had an ADL self-care performance deficit. The goal was the resident would improve his current level of function through the review date. Interventions included the resident required substantial assistance with bed mobility, eating, and with personal hygiene/oral care; and resident was totally dependent on staff for bathing, and toileting. Review of the medical record revealed no care plan was ever initiated for resident #3's actual pressure wound. Review of the Braden Score for Predicting Pressure Ulcer Skin Risk completed on admission [DATE] reflected the resident was at moderate risk for a pressure ulcer. Subsequent Braden scales completed on [DATE] and again on [DATE] scored resident #3 as low risk for developing a pressure sore, even after he was found to have developed one. A progress note dated [DATE] at 8:00 PM, by Registered Nurse (RN) D revealed an open area on the right buttock was discovered and the family, primary physician and the wound care team were notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 5:44 PM, CNA B said, I do remember resident #3, he was confused but he would smile and try to talk to us. I tried to keep him on his side because he ended up with a pressure ulcer. I even talked to the night shift to try to keep him off his back it went from a tiny little area to a bigger area in three days while I was off. CNA B stated she recalled when resident #3 was not on her assignment, he would be lying on his back or in a chair. The CNA said the family visited him often and expressed concern about his wound. Review of the medical record revealed no documentation by Certified Nursing Assistants (CNAs) after [DATE] regarding resident #3's pressure wound, except on shower sheets dated [DATE] which indicated redness in the sacral area. On [DATE] and [DATE] the CNA documented on the shower sheet there was no indication of a skin condition in conflict with other documentation in the medical record. All 4 sheets were signed by the Charge nurse as having being reviewed. The CNA Kardex dated as of [DATE] also had no documentation which indicated resident #3 had a pressure wound. Review of the Weekly Skin Integrity Review sheets, completed by nurses, revealed a skin sheet dated [DATE] was the first time resident #3's skin was noted as not intact. The skin sheet did not have documentation of the location or a description of the wound. There was no documentation of skin sheets again for over 3 weeks until [DATE]. Review of a progress note dated [DATE], Advance Practice Registered Nurse (APRN) A documented, Deconditioning/ Gait instability- Patient is high risk for functional impairment without therapy and adequate pain control. Patient has high risk for developing contractures, pressure ulcers, poor healing, or fall if not receiving adequate therapy and pain control. Review of the Pressure Ulcer Wound Round sheets completed by the wound nurse initially on [DATE] revealed resident #3 had a stage III pressure ulcer to his sacrum which measured 5 centimeters (cm) by 5.5 cm by 0.3 cm with 30 percent slough (dead tissue within a wound) and 20 percent necrosis. The treatment was documented as silver alginate. A week later on [DATE] the Pressure Ulcer Wound Round sheets showed resident #3's wound had deteriorated to a stage IV with 70 percent necrosis and a wound bed which had turned black. The size of the wound also increased to 9 cm by 7 cm by an unable to determine measurement. The treatment was documented as Medical grade honey. On [DATE], a month after the wound was initially found, the Pressure Ulcer Wound Round sheets showed resident #3's sacral pressure wound was still a stage IV that now measured 12 cm by 7 cm with a depth that was still unable to be determined. The treatment was now documented as silver alginate and moistened gauze. On [DATE] at 9:20 AM, the Wound Care RN confirmed resident #3 had a facility acquired pressure ulcer that declined rapidly in the month after it was found. She said when the assigned nurse notifies her of a resident's wound she would enter the orders for what the resident needed for wound healing such as wound care or an air mattress, and complete a weekly skin note. The Wound Care RN said she did not usually measure the wounds, unless the physician did not come to see the resident. She explained she would classify the stage of the wound at that time and document her assessment of the wound. The Wound Care RN stated she had put orders in for resident #3 but said they were, missing from his medical record. She confirmed resident #3's facility acquired wound was not discussed in the clinical meeting and explained nurses did not always tell them when they found a skin impairment or wound. The Wound RN recalled sometimes nurses would sign off orders in the Treatment Administration Record (TAR) when they did not complete them themselves. She explained she had been told previously that it was okay for the floor nurses to document the treatments even if they were not the ones doing them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 0686 Level of Harm - Actual harm Residents Affected - Few	Although the wound was discovered on [DATE], the first visit by the wound physician did not take place until [DATE] per the consult note which revealed the wound was a stage III unhealed pressure ulcer. Per the physician's note the wound was debrided that day to remove devitalized tissue, biofilm, eschar and slough. The consult note listed wound orders which included, cleanse/irrigate with normal saline/water, keep the area dry and clean, apply calcium alginate with silver, and cover with foam dressing. Additional orders included for nursing to change dressing every day and as needed, implement pressure relieving measures and offloading as tolerated and a consult from the Registered Dietician to implement a nutritional plan, protein supplements, and daily multivitamins. Review of additional wound physician notes indicated the total surface area of resident #3's wound increased from 27.5 cm squared on the first visit of [DATE] to 84 cm squared a month later on [DATE]. On [DATE] at 11:23 AM, the wound physician stated he came to the facility weekly, but no longer worked at the facility. He explained when a new wound was identified at the facility, nursing staff would notify him, and he would see that resident on his next visit to the facility where he would update them with any orders he wanted to implement. The wound physician clarified he would also add interventions in his notes if he saw they were not already in place, as he did on [DATE]. He recalled resident #3 and explained his wound deteriorated over the three weeks until [DATE] when he was transferred to the hospital upon his family's request. The wound physician stated the facility implemented floor nurses to perform wound care instead of the wound nurse. He said, I cannot attest that if the nurses were busy, the [resident's] wound care was done. He explained he didn't anticipate how quickly resident #3's wound would deteriorate. Review of the TAR for [DATE] revealed no orders for wound treatments were initiated until [DATE], nine days after the wound was first noted by the CNA. The Medication Administration Record for April and [DATE] revealed supplements for wounds were not ordered until [DATE], 13 days after the Dietary consult was ordered by the wound physician. Review of the TAR reflected during the 19 days from [DATE]-[DATE] nursing staff documented the resident received a total of ,d+[DATE] dressing changes as ordered by the physician for his pressure wound. On [DATE] at 3:50 PM, the Regional Nurse confirmed wound care was not done as ordered for resident #3. She stated education for the expectation of accurate documentation was implemented and two staff were terminated after the concern about wound care not being done was found by the Interdisciplinary team on [DATE]. She explained this was an ongoing Performance Improvement Project with active audits but confirmed resident #3 was not included in their audits and the concerns found during the survey were not discovered by the facility until brought to their attention by the survey team. A progress note on [DATE] at 12:48 PM, by the indicated, Resident's family requested that he be transferred to the Emergency Department (ED) due to his sacrum wound not healing and his urinary catheter needing to be changed. APRN C was notified of the request and went to assess the resident and determined that the concerns brought up by the family could be treated at our facility. Family continued to insist that we send him to the ED. 911 was called and the resident was sent to the ED . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 0686 Level of Harm - Actual harm Residents Affected - Few	Hospital records dated [DATE] to [DATE] revealed the resident had severe sepsis from an unstageable sacral wound when he arrived at the ED. Cultures were taken from the wound and the resident was given intravenous (IV) antibiotics. Results of the wound cultures revealed the wound was growing extended-spectrum-beta-lactamase (ESBL), Klebsiella pneumonia and methicillin resistant staphylococcus aures (MRSA). The hospital record revealed resident #3 had another bed side debridement in the hospital by the surgeon. The surgical note indicated infected, necrotic, gangrenous tissue was excised from the sacral wound which extended to the bone. The hospital record indicated the resident died approximately a month later on hospice. ESBL which are enzymes or chemicals produced by germs like certain bacteria. These enzymes make bacterial infections harder to treat with antibiotics (retrieved on [DATE] from www.webmd.com.) MRSA is a staphylococcus germ (bacteria) that does not get better with the type of antibiotics that usually cure staphylococcus infections (retrieved on [DATE] from www.ncbi.[NAME].nih.gov). The job description, Wound Care Nurse dated [DATE] detailed the job function of being delegated the administrative authority, responsibility and accountability to carry out assigned duties. Responsibilities included provide direct resident care in assessment, treatment and follow up for wound management as ordered by the physician; complete required documentation in an accurate and timely manner; and collaborate with the Interdisciplinary Team to encompass all aspects of care to promote wound healing. Review of the Clinical Guideline Skin & Wound policy and procedure effective date [DATE] revealed the purpose to provide a system to identify at risk skin, implement individual interventions including evaluation and monitoring, healing and to decrease worsening of and the prevention of pressure injuries. The procedure indicated the licensed nurse was to complete the skin evaluation weekly and document in the medical record, develop individualized goals and interventions and document on the care plan and CNA Kardex.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 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** 51023 Based on observation, interview, and record review, the facility failed to implement fall interventions for 1 of 1 residents reviewed for falls, of a total sample of 17 residents, (#2). Findings: Resident #2 was admitted to the facility from an acute care hospital on 3/07/24 with a diagnosis of drug induced subacute dyskinesia (uncontrolled, involuntary movements). Other diagnoses included Alzheimer's disease, spinal stenosis, muscle weakness, difficulty walking, unspecified abnormalities of gait and mobility, and Parkinson's disease with dyskinesia. Review of hospital discharge papers dated 3/05/24, revealed a handwritten note that stated, Ok to accept. No clinical reason not to accept except safety concerns with falls due to [diagnoses] of dyskinesia and involuntary movement. Review of the admission assessment dated [DATE] revealed the resident's cognition as alert to person with memory problems. The assessment indicated resident #2 was noted to have fallen within the last 30 days. A progress note attached to the assessment detailed the resident had physical irritability due to diagnosis. It also indicated the resident was a fall risk per the family. The care plan initiated on 3/08/24, listed the resident had an actual fall with no injury. The goal for the resident would be to resume usual activities and minimize the risk of further incident through next review. Interventions included bed in lowest position on 3/08/24, bilateral fall mats on 3/11/24 and a perimeter defined mattress on 3/19/24. The Minimum Data Set (MDS) assessment, dated 3/14/24, noted a Brief Interview for Mental Status score of 13 which indicated the resident was cognitively intact. The resident was noted to have had 2 or more falls with no injury prior to admission. Review of the activities of daily living section of the assessment indicated the resident required extensive assist of 2 persons for bed mobility and transfers. The assessment showed the resident required maximal or substantial assistance for toilet hygiene and was dependent for shower/bathing self, dressing lower body, and personal hygiene. Resident required moderate or partial assistance for going from lying to sitting on the side of the bed and sitting to standing. Review of resident's clinical record revealed he sustained a fall without injury on 3/07/24, the day of admission, and another on 3/19/24. Following the 3/07/24 fall, bilateral fall mat intervention was added to the resident's care plan. Review of the fall investigation report dated 3/19/24 revealed the resident got out of bed unassisted and he was found by the nurse, supine (flat on one's back), laying bedside and unable to explain what happened. Neither the report nor the statement mentioned whether fall mats were in place at the time of the fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurses progress note on 3/19/24 at 7:15 PM, revealed the resident was found lying supine bedside. The nurse documented it was an unwitnessed fall, neuro-checks were initiated, fall reports were generated, the family and MD notified. Review of the resident's clinical record revealed no order for the bilateral fall mats initiated as a fall care plan intervention on 3/11/24. Review of the Certified Nursing Assistant (CNA) care plan/Kardex revealed no tasks for bilateral fall mats. On 3/18/24 at 1:21 PM, the MDS coordinator stated there typically wasn't an order in the Medication Administration Record or the Treatment Administration Record for fall mats. She stated those interventions typically only appeared in the care plan and the CNA task/Kardex. On 3/18/24 at 2:32 PM, the Director of Nursing (DON) revealed that typically the care plan would automatically upload the interventions to the CNA Kardex. She explained this would show the CNAs if the resident needed special interventions such as fall mats. The DON indicated no one verified that care plan interventions were correctly uploaded to the CNA Kardex. She confirmed resident #2's CNA Kardex did not have the fall interventions from the care plan such as fall mats listed. The DON then checked the computer and confirmed the care plan, Kardex and resident's clinical chart. She again confirmed the bilateral fall mats were not listed as a task for the CNAs to complete. In a later interview with the DON on 3/18/24 at 2:43 PM, she confirmed the bilateral fall mats should have been in place following resident #2's fall on 3/07/24. She said she could not find documentation that the bilateral fall mats were in place before the residents second fall on 3/19/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43192 Based on interview and record review, the facility failed to maintain a medical record that accurately documented activities of daily living (ADLs) for 3 of 3 residents reviewed for ADLs, of a total sample of 17 residents, (#4, #14, and #17). Findings: 1. Review of resident #4's medical record revealed she was admitted to the facility on [DATE] with diagnoses including multiple sclerosis and aphasia. Review of resident #4's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 6/13/24 revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating severely impaired cognition. She was totally dependent on staff for ADLs. Review of resident #4's CNA (Certified Nursing Assistant)-ADL Tracking Form for May 2024 revealed eating was documented 11 out of 31 days on the 3 PM to 11 PM shift, and 0 out of 31 days on the 7 AM to 3 PM shift. Meal consumption percentage was documented on 27 days from the 3 PM to 11 PM shift, 0 out of 31 days for the 7 AM to 3 PM shift (breakfast and lunch). Review of the CNA- ADL Tracking Form for June 2024 revealed eating was not documented 6 out of 18 days for the 7 AM to 3 PM shift, and 10 out of 18 days for the 3 PM to 11 PM shift. Meal consumption percentage was documented only 1 out 18 days for breakfast, 10 out 18 days for lunch, and 5 out of 18 days for dinner. Fluids were documented as offered on 10 out of 18 days for the 7 AM to 3 PM shift and 10 out of 18 days on the 3 PM to 11 PM shift. 2. Review of resident #14's medical record revealed he was admitted to the facility on [DATE] with diagnoses including stroke, hemiplegia affecting the left non-dominant side, type 2 diabetes and glaucoma. Review of resident #14's quarterly MDS assessment with ARD of 5/23/24 revealed a BIMS score of 15 out of 15, indicating intact cognition. He required substantial assistance from staff with lower body dressing and partial/moderate assistance with toileting hygiene and to shower or bathe. Review of resident #14's CNA-ADL Tracking Form for May of 2024 revealed documentation for dressing, personal hygiene, toilet use, eating for 1 out 31 days on the 7 AM to 3 PM shift, meal consumption percentage was documented on 1 of 31 days for breakfast, 0 of 31 days for lunch and 5 of 31 days for dinner. 3. Review of resident #17's medical record revealed she was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, Parkinsonism, and type 2 diabetes. Review of resident #17's annual MDS assessment with ARD of 5/11/24 revealed a BIMS score of 0 out of 15, indicating severely impaired cognition. She was totally dependent on staff for all ADLs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #17's CNA-ADL Tracking Form for May of 2024 revealed documentation for dressing, personal hygiene, toilet use, and eating was missing for the entire 7 AM to 3 PM shift. Meal consumption percentage was documented for only 1 of 3 meals for the entire month. The form for June 2024 showed meal consumption percentage was documented on 5 of 18 days for breakfast, 6 of 18 days for lunch, and 7 of 18 days for dinner. Fluids were documented as offered on 13 of 18 days for the 7 AM to 3 PM shift and 7 of 18 days for the 3 PM to 11 PM shift. On 6/18/24 at 5:45 PM, CNA B stated they did not have tablets and had to document ADLs on paper. She mentioned they had been told they would get tablets again which she felt were faster to document on. She explained that currently CNAs had 16 pages on which they had to document ADLs for each resident assigned. On 6/18/24 at 1:24 PM, CNA G stated documentation of assigned tasks was done on paper, but she told the Director of Nursing (DON) she cannot hardly see the form in order to document, her eyes are crying. She explained they tried to make the letters bigger but now she had not found the ADL book. She also stated each resident had 16 pages for ADL documentation. She said , If you have 12 residents times 16 pages, [it] is too much. She stated she had not documented ADL care for a few months on any of her residents. She indicated she did not tell the nurse or the Unit Manager (UM) about not being able to find the ADL book. On 6/20/24 at 2:00 PM, the North Wing UM stated she was unaware CNAs were not documenting ADLs for residents #4, #14, #17. She stated some CNAs had expressed their concerns with the small lettering on the form, so she made the font bigger which created the 16 pages. She indicated the ADL binder was located in the nurse's station. On 6/20/24 at 4:27 PM, the Administrator and DON looked at the ADL documentation for residents #4, #14, and #17 and confirmed the medical records were inaccurate. The Regional Nurse Consultant stated CNAs had been educated many times. She said it was a matter of diligently micromanaging the full house. Review of the facility policy and procedure titled Clinical/Medical Records revised on 8/25/17 read, Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care.