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	09/19/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35086 Based on interview and record review; the facility failed to investigate after a resident was found with suspected illicit drugs for 1 of 1 resident reviewed, (#11), of 17 sampled residents. Findings: Resident #11 a [AGE] year-old male was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included absence of bilateral legs above the knees, diabetes type 2, peripheral vascular disease, chronic obstructive pulmonary disease, depression, phantom limb pain syndrome, heart failure, repeated falls and nicotine dependence. On 8/11/24 at 1:40 AM, the weekend supervisor nurse documented a behavior note that read, Resident found by this nurse at [1:30 AM] to be sitting in wheelchair on patio area between timeclock and South wing dayroom passed out, slow to arouse. Resident leaning forward towards concrete, eyeglasses on ground in front of him, pack of cigarettes on ground. This nurse assisted CNA [Certified Nursing Assistant] to return resident to room. When pack of cigarettes picked up from concrete there was a small plastic bag with suspected illicit street drug rolled in partially burned paper which was confiscated. MD [Medical Doctor] made aware. Nursing informed to hold all Narcotics at this time and continue to manually check BP/pulse just prior to giving them in the future. Review of the facility incident log showed no incidents investigated regarding nurse finding suspected illicit street drug in resident #11's possession. On 9/19/24 at 10:30 AM, the facility [NAME] President (VP) of Operations read the weekend supervisors' note dated 8/11/24 at 1:40 AM and acknowledged there should have been an incident on their log, police called and note documented to say who disposed of the suspected illicit drugs. (continued on next page)

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

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

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24 at 11:00 AM, the North Wing Unit Manager and Director of Nursing (DON) said they had no knowledge of an incident regarding a suspicion by staff that resident #11 had/used illicit street drugs. The Unit Manager said she was on leave at the time of the incident (8/11/24) and the nurse who cared for the resident that night no longer worked here and therefore was not available for interview. The DON and Unit Manager said staff were not suppose to dispose of suspected illicit drugs, law enforcement should have been called to do that. They explained the nurse could have taken a picture of the drugs, we could have checked with the doctor to see if he wanted a drug test done on the resident, then initiated an incident report and investigation. They said their investigation would have included getting statements from the resident and staff, as well as updating his comprehensive care plan to ensure other staff were aware of the incident. The DON and Unit Manager explained the process that the Weekend Supervisor should have called the On-call Supervisor who would have then informed the DON or the Nursing Home Administrator of the incident. They could have then directed the staff as to the appropriate steps to take. They both verbalized the staff were never to dispose of suspected illicit street drugs. On 9/19/24 at 2:00 PM, in a telephone interview with the weekend supervisor she said, she found resident #11 outside, in the enclosed patio area on property after hours and he was asleep and seemed lethargic. She got the CNA to assist him back into the building and to his room. She explained, the small plastic bag fell out of his cigarette pack and had less than inch long of partially burned non-filter paper, and she was not sure if it was marijuana or a cigarette. It was such a small amount that, I flushed it down the toilet because I could not identify it. The Weekend Supervisor added, it was the On-call Supervisor who told her to flush it down the toilet and the physician told me to hold the resident's narcotics and monitor him. The DON who was present during the interview said the On-call Supervisor at that time was the South Wing Unit Manager who no longer worked there. The Weekend Supervisor verified she had not received any education on how to dispose of illegal drugs. She stated she did not have 2nd nurse witness her flush the potential illegal drug down toilet, and she did not know to initiate an incident report. Review of the facility policies and procedures for Accident and Incident Investigation effective 11/30/14 read, Certain accident and incident, including injuries of unknown origin, medication discrepancies and adverse drug reactions will be investigated to determine root cause and provide for opportunity to decrease future occurrences of the event .A happening that is not consistent with routine operations of the facility or care of resident will warrant the completion of an incident report .Notification must be made to the following: Resident representative, physician, the Executive Director, Director of Nursing, or their designee, must begin a documented investigation The investigation will include interviews with the resident, all staff involved The investigation must be thoroughly documented using the Investigative Report form The facility must use the Performance Improvement process for problem identification and corrective action when necessary.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35086 Based on interview and record review, the facility failed to update an individualized care plan for potential for adverse drug interactions for 1 of 1 reviewed for opioid and antianxiety medications, of a total sample of 17 residents, (#11). Findings: Resident #11, a [AGE] year-old male was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included absence of bilateral legs above the knees, diabetes mellitus type 2, peripheral vascular disease, chronic obstructive pulmonary disease, depression, phantom limb pain syndrome, heart failure, repeated falls and nicotine dependence. On 8/11/24 at 1:40 AM, the Weekend Supervisor documented a behavior note that read, Resident found by this nurse at [1:30 AM] to be sitting in wheelchair on patio area between timeclock and South wing dayroom passed out, slow to arouse. Resident leaning forward towards concrete, eyeglasses on ground in front of him, pack of cigarettes on ground. This nurse assisted CNA [Certified Nursing Assistant] to return resident to room. When pack of cigarettes picked up from concrete there was a small plastic bag with suspected illicit street drug rolled in partially burned paper which was confiscated. MD [Medical Doctor] made aware. Nursing informed to hold all Narcotics at this time and continue to manually check BP[blood pressure]/pulse just prior to giving them in the future. On 8/13/24 Advance Practice Registered Nurse (APRN) D documented, CHIEF COMPLAINT: Urgent visit. The pt [patient] had a fall. Received message notable the pt [patient] was lethargic with slurred speech from the lobby by supervisor nurse. He had slight bleed with laceration on the right side of forehead. There was order to send the pt to hospital. Pt refuse .Seeing the pt today he states he fell out of bed because he was having a bad dream. It was reported to me that the pt was doing drugs outside of the building and return as described above. Pt reports cocaine [a few days ago]. His VS [vital signs] are stable. He has small abrasion to the right forehead . On 9/19/24 at 2:00 PM, in a telephone interview the Weekend Supervisor said she found resident #11 outside, in the enclosed patio area on property after hours. She stated he was asleep and seemed lethargic so she got the Certified Nursing Assistant (CNA) to assist him back into the building and to his room. She explained, a small plastic bag fell out of his cigarette pack which had a less than inch long partially burned rolled non-filter paper, and she was not sure if it was marijuana or a cigarette. It was such a small amount that I flushed it down the toilet because I could not identify it. The Weekend Supervisor added, it was the On-call Supervisor who told her to flush it down the toilet and the doctor told me to hold his narcotics and monitor the resident. The Director of Nursing (DON) who was present during the interview said the On-call Supervisor at that time was the South Wing Unit Manager who no longer worked here. The Weekend Supervisor verified she had not received any education on how to dispose of illegal drugs, nor did she have a 2nd nurse witness her flush the potential illegal drug down the toilet. She also stated she did not know to initiate an incident report. The Weekend Supervisor stated she was not aware of any other incidents with resident #11 using any illegal drugs at the facility or off property. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of current orders for resident #11 included the medication Alprazolam 1 milligram (mg) by mouth at bedtime for anxiety since 10/21/23, Morphine Sulfate ER (extended release) 15 mg, give 2 tablets every 8 hours for pain since 7/22/24 and Morphine Sulfate 15 mg by mouth every 12 hours as needed for moderate to severe pain since 7/30/24. Review of resident #11's comprehensive care plans included use of anti-anxiety medications related to anxiety disorder, use of antidepressant medications related to depression, pain medication therapy related to chronic pain and phantom pain status post amputation. The resident had a total of 25 pages of care plans but they did not contain a plan or intervention related to the incident on 8/11/24 involving possible illicit drug use nor of the note on 8/13/24 when the APRN documented cocaine use by the resident a few days ago. On 9/19/24 at 12:58 PM, the Nursing Home Administrator (NHA) and DON acknowledged the APRN never reported the recent use of cocaine to the, nor were they aware until the time of the survey that nurse found possible illicit drugs on the resident 8/11/24. The DON verified that at that time he did not have a revised plan of care regarding potential for adverse drug interactions since he was on prescription medications that included Alprazolam and Morphine, which could interact with illicit drugs or cocaine. Review of the facility policy and procedure for Plan of Care revised 9/25/24, read, An individualized person centered plan of care will be established by the interdisciplinary team [IDT] with the resident and/or resident representative .Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident .the plan is oriented toward attaining or maintain the highest practicable, physical, mental and psychosocial well-being

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35086 Based on observation, interview and record review, the facility failed to ensure a safe smoking environment for 10 of 10 residents reviewed for smoking, of a total sample of 17 residents, (#11, #15, #16, #17, #18, #19, #20, #21, #22, #23). Findings: On 9/18/24 at 10:45 AM, resident #11 was observed in his room sitting on the edge of his bed. He was noted with bilateral high above the knee leg amputations. On his night table next to the bed in clear view was a pack of cigarettes and lighter. He was alert and oriented to person, place, and time. He said that some of the residents were allowed to keep their cigarettes and lighters, but staff did hold some of the residents' lighters. On 9/18/24 at 11:20 AM, residents #11, #15, #16 and #17 were observed outside smoking on the patio, with no staff present outside on the patio. None of the residents had on smoking aprons and resident #11 lit resident #15's cigarettes with his own lighter. The four residents present smoking used an ashtray on the patio table that was overflowing with old cigarette butts as well as one butt that was still burning. The Staffing Coordinator was noted standing inside the building watching the residents through a window while residents were outside smoking on the patio approximately 20-30 feet away. The Staffing Coordinator said none of the residents in the building needed an apron to smoke and since resident #15 was blind, resident #11 lit her cigarettes. Resident #11 confirmed he lit resident #15's cigarettes because she was blind. Resident #15 voiced she did have her own lighter and was not going to return it to staff when they were done smoking. The staffing coordinator made no attempt to come out and light residents' cigarettes, to stop resident #11 from lighting other residents' cigarettes, nor to empty the overflowing ashtray. The staffing coordinator did not notice that when resident #16 finished smoking, he re-entered the building via self-propelling in his wheelchair and still had 1/2 pack cigarettes with a lighter in his possession. She did not ask the resident to return his smoking materials to be kept safely by the facility. On 9/18/24 at 11:25 AM, the Central Supply staff said she came to relieve the Staffing Coordinator and supervise the smokers. She explained her role when supervising smoking activity was to ensure the residents were smoking safely. She said the residents were not supposed to keep their own lighters but some of them could hold onto their cigarettes and staff should light their cigarettes for them. The Staffing Coordinator also remained inside while residents #11, #15, and #17 were still outside smoking. The Central Supply staff was unaware residents #11 and #15 both had their own lighters, and she did not go outside to empty the ashtray that was 75% full on the patio table with burning cigarette butts present. On 9/18/24 at 11:27 AM, the Director of Nursing (DON) came outside to the smoking area while residents #11, #15, and #17 were noted outside still smoking and explained the residents were supposed to return their lighters when they were done smoking. The DON was informed that resident #16 had already finished smoking and was observed re-entering the building after smoking with his lighter on his person and staff did not attempt to retrieve his lighter. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/18/24 at 12:00 PM, the Nursing Home Administrator (NHA) provided the schedule of various staff that were supposed to supervise the smokers which included: restorative certified nursing assistants (CNA), Activities assistant, Social Service personnel, the Staffing Coordinator, the North Wing Unit Manager, the Wound Nurse, the Manager on duty, the Weekend Supervisor, the Medical Records staff, the Central Supply staff, and the North and South units CNAs with assignments 1 thru 5. The education that staff most recently attended was 3/26/24. The NHA verified they only reviewed the policy with the staff and had no special training or test for the staff who supervised the resident smoking activity. The facility NHA provided a list of 10 residents who participated in the smoking activity. Of the residents on the list, residents #17 and #22 were assessed with severe cognitive impairment and #21 and #15 had moderate cognitive impairment. Resident #15's Smoking Evaluation dated 5/24/24 revealed that her vision is not adequate, and she is not able to safely light her own cigarettes. Under the comments section nurse documented, Resident is legally blind and will need a staff member to light her cigarette and place her hand on the ashtray. Resident #15's care plan dated 5/29/24 for being a smoker had goal that she will not smoke without supervision and interventions included to provide supervision while smoking and requires a smoking apron. Resident #17's Smoking Evaluation dated 7/16/24 showed he had short- and long-term memory impairment and was deemed an unsafe smoker. His smoking care plan revised 8/16/23 with the goal he will not suffer injury due to unsafe smoking included intervention to provide a smoking apron. Resident #21's smoking care plan revised 6/11/24 included intervention that he required supervision while smoking. Resident #22 smoking care plan dated 1/19/24 showed that he required supervision while smoking. Resident #23's smoking care plan revised on 8/16/23 showed that he does require supervision and although he can light his own cigarettes, post activity his lighter is turned into staff and kept in a lock box. He was educated on 8/16/24 regarding relinquishing lighter possession policy. On 9/18/24 at 1:12 PM, again there were 8-10 residents seen smoking on the outside patio. Activities Assistant B was present inside the building but said she could see the smokers outside through the large glass window on the unit. She said she usually provided smoking supervision in the morning and at 3:30 PM. She explained she stayed inside because she could be around smoke due to her medical condition. She did not know what the facility smoking policies and procedures were for residents. The Activities Assistant said most of the residents were high functioning and able to keep their own lighters, but she was not sure of the facility rules. She verified it was difficult for her to properly supervise residents smoking from inside the building while they were outside, and she did not realize she should go outside with them. While interviewing the Activities Assistant there were approximately 4 to 5 residents observed sitting at the patio table passing around a lit cigarette to light their unlit ones. The DON was now present outside with the smokers and did not notice this behavior or stop the residents from lighting their cigarettes from an already lit one. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/18/24 at 3:22 PM, the NHA verified the staff should instruct residents participating in the smoking activity to not light each other's cigarettes or use other residents' lit cigarettes to light them. She added that after the activity, staff were to retrieve any lighters and safeguard them until the next scheduled smoke time activity. The NHA explained if the residents were not following the smoking policies staff were to report it to them so that they could re-educate the resident on the policies and they would issue a 30-day notice if they continued to not follow the rules. On 9/18/24 at 4:39 PM, the DON said, the staff who provided smoking supervision for residents should be outside sitting with the residents while they were smoking to ensure they were smoking safely and to intervene if they were not. The DON verified the staff should light residents' cigarettes and not allow them to light each other's cigarettes off already lit ones. The DON added the staff were to report to a supervisor if residents were not following the smoking policies so that they could intervene and give 30-day discharge notices if warranted. Review of the facility's policies and procedures for Smoking-Supervised, revised 2/07/20 read, The Center will provide a safe, designated smoking area for resident. For the safety of all residents the designated smoking will be monitored by staff member during authorized smoking times The center will have safety equipment available in designated smoking area including smoking blankets, smoking aprons, a fire extinguisher and no combustible self-closing ashtrays 4. During designated smoking times staff will be assigned to assist or supervise resident whose care plans indicate assistance or supervision is required while smoking. 5. The Center will retain and store matches, lighters, etc. for all residents. 6. All residents who wish to smoke will sign an agreement attesting to abide by the smoking policies and procedures. 7. Residents will be advised upon admission that violations of the smoking policies may result in revocation of smoking privileges, discharge, and /or report to law enforcement .9. Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51234 Based on observation, interview, and record review, the facility failed to provide intravenous (IV) care and services according to standards of practice and plans of care for 2 of 2 residents reviewed for IV care, of a total sample of 17 residents, (# 2, and #18). Findings: 1. On 9/18/2024 at 12:14 PM, resident #2 was observed with a midline intravenous (IV) catheter in her right upper arm with a transparent dressing. There was no date on the dressing noted. Resident #2's medical record revealed that on 9/04/24 an Advanced Practice Registered Nurse ordered that due to the results of a Urine Analysis with a Culture and Sensitivity the resident was ordered Imipenem-Cilastatin (an antibiotic) Intravenous Solution Reconstituted 250 milligrams (mg) IV every 6 hours for 7 days. Resident #2's medical record contained a nursing note dated 9/09/24 that indicated the IV on the resident' s left forearm was not functioning for use for medication administration, and the company IV Access was contacted to place a new IV site. Resident #2's medication administration record for September 2024 revealed Imipenem-Cilastatin was administered intravenously from 9/05/24 through 9/11/24. 9/18/24 at 2:15 PM, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) observed resident #2's right upper arm midline IV catheter site. They verified there was no date on the transparent dressing covering the insertion site, and verified there should be a date on the dressing if the dressing had been changed. The DON reviewed the orders section of Resident #2's medical record and noted there was an entry on 9/09/24 that the left arm IV was unable to be flushed, and no right upper arm midline IV catheter site was noted. The Facility's Catheter Insertion and Care policy specific to midline catheter dressings stated such catheter dressings would be changed at intervals and as needed to prevent catheter related infections associated with contaminated, loosened, or soiled catheter site dressings. The General Guidelines of this policy indicated to change a midline catheter dressing 24 hours after catheter insertion, and every 5-7 days, or if it was compromised in any way. On 9/18/24 at 4:30 PM, the DON verified there were no documentation that resident #2's midline IV catheter in her right upper arm dressing had been changed since its placement on 9/09/24. Not 24 hours after insertion nor after 7 days post insertion. She stated she had called resident #2's physician to discontinue the placement of the right upper arm midline IV catheter. She verified that 09/11/24 was the date when the last dose of the IV medication had been administered to resident #2, seven days earlier. 35086 (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident # 18 was admitted to the facility on [DATE] and readmitted from an acute care hospital on 9/10/24. His diagnoses included infected surgical wound left foot, orthopedic aftercare of amputation, acute osteomyelitis left ankle/foot, amputation left great toe and diabetes type 2. Review of the AHCA (Agency for Healthcare Administration) Transfer Form 5000-3008 from the hospital dated 9/10/24 revealed he had a peripherally inserted central catheter (PICC) line in his right upper arm. A PICC line is a thin, flexible tube that is inserted into a vein in the upper arm and guided (threaded) into a large vein above the right side of the heart called the superior vena cava. It is used to give intravenous fluids, blood transfusions, chemotherapy, and other drugs, (retrieved on 9/20/24 from www.cancer.gov). On 9/18/24 at 1:45 PM, resident #18 was observed sitting up in his wheelchair outside on patio smoking. He was alert and oriented to person, place, time and situation. He was noted with a PICC line in his right upper arm and the dressing was dated 9/06/24. He said he was getting antibiotics in his IV line three times per day for an infection in his foot. He expressed concerns that no one at the facility has changed the IV dressing or the green cap on the IV tubing since he recently returned from the hospital. On 9/18/24 at 1:40 PM, resident #18's assigned Registered Nurse (RN) A validated the dressing on his right arm was greater than seven days old and should have been changed by 9/13/24, five days previously. RN A admitted she had not cared for him the last couple of days but did over the weekend and should have changed it then. She explained the reason she did not change it was because she did not see it on her schedule to be done. She verified even if not on her schedule it should have been changed every 7 days and as needed. Review of the medical record for resident #18 showed he had an order dated 9/14/24 for nurses to change the IV dressing every week and as needed, PICC line flush with 10 milliliters of normal saline every shift and prn (as needed), and Meropenem (antibiotic) 1 Gram IV every 8 hours for 20 days. Resident #18's comprehensive plan of care was initiated on 9/10/24 for IV medication due to osteomyelitis and included interventions to change the IV dressing and record observation of the site every shift. Review of the Medication Administration Record revealed there were five nurses on two different shifts that gave him IV mediations from 9/14/24 to 9/18/24 and missed the opportunity to change his IV dressing when they accessed the site to give the antibiotics. On 9/18/24 at 4:54 PM, the Director of Nursing (DON) was informed of the concern regarding resident #18's IV dressing not being changed for 13 days. The DON said the nurses were expected to follow standards of nursing practice and change IV dressings every 7 days for a clear dressing or every 2 days if unable to see the site. The DON added she would need to check with the manufacturer or pharmacy for how frequently to change the green cap on the IV tubing and thought nurses should change it at least daily. The DON verified any of the nurses giving his IV medications should have noticed the dressing was out of date and changed it sooner. The DON said she would follow up regarding the green cap and would inform the staff how often and when to change it. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy for Catheter Insertion and Care revised 1/17/19 read, Central venous catheter dressings will be changed at specific intervals, or when needed, to prevent catheter related infections Change transparent semi-permeable membrane [TSM] dressing at least every 5-7 days and prn .If gauze is used, it must be changed every 2 days The following information should be recorded in the resident's medical record: 1. Date and time dressing was changed .

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Aspire at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51234 Based on observation, interview, and record review, the facility failed to obtain a physician order for Oxygen (O2) therapy and failed to administer O2 therapy as ordered by the physician for 2 of 2 residents reviewed for O2 therapy, of a total sample of 17 residents, (#2, #13). Findings: 1. On 9/18/24 at 12:14 PM, resident #2 was observed seated in her wheelchair with a nasal cannula in her nose. The O2 tubing connected to an oxygen tank on the back of her wheelchair. The O2 flow rate indicated on tank was 3 liters per minute (L/min). Review of resident #2's medical record revealed she was readmitted to the facility on [DATE] from the hospital. Her diagnoses included: Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Cardiomegaly, and unspecified sequelae of unspecified cerebrovascular disease. There was no physician's order for oxygen. On 9/18/24 at 2:07 PM, Licensed Practical Nurse (LPN) E, resident #2's assigned nurse, verified she had seen resident #2 with her O2 nasal cannula in her nose that day attached to the tank at the back of the resident's wheelchair. She said she thought the flow rate for resident #2's oxygen was 3 liters per minute (L/min). LPN E examined resident #2's medical record and verified she could not find a current physician's order for oxygen use in Resident #2's record. On 9/18/24 at 2:15 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) observed resident #2 seated in her wheelchair with nasal cannula in place, oxygen tubing connected to the oxygen tank behind her wheelchair. The DON verified the flow rate indicated on the oxygen tank was 3 L/min. The DON verified the oxygen tank regulator on the back of resident #2's wheelchair indicated an empty tank. On 9/18/24 at 4:30 PM, the DON verified resident #2 did not have a physician's order for oxygen use, to determine the flow rate nor when it should be used. She said she thought resident #2 should have had an order because she had recently used it in the facility. She thought the order might have been mistakenly dropped from resident #2's record when the resident had been readmitted from the hospital. 35086 2. Resident #13 was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included respiratory failure, chronic obstructive pulmonary disease (COPD) and adult failure to thrive. On 9/18/24 at 10:35 AM, resident #13 was observed lying in bed asleep wearing O2 via nasal cannula (NC) with her O2 concentration set at 4 L/min. (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	09/19/2024

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/18/24 at 1:08 PM, resident #13 again was observed lying in bed on her right side with her O2 at 4 L/min via NC. She was more alert at this time and pleasantly confused. The O2 concentrator was untouched from earlier and remained on the left side adjacent to her bed and was not within her reach. Review of the medical record revealed resident #13 had physician orders for continuous oxygen at 2 L/min via NC. Review of the comprehensive care plans for COPD and Altered Respiratory status included interventions to give oxygen per physician orders and did not show any behaviors regarding the resident adjusting her own oxygen settings. The goal of the plan of care was that she would have minimal complications related to shortness of breath. On 9/18/24 at 2:00 PM, the assigned Licensed Practical Nurse (LPN) C checked the medical record and confirmed the resident was supposed to get her O2 at 2 L/min. The nurse then went into the resident room where resident was noted still on her right side in bed wearing her oxygen via NC set at 4 L/min and the nurse then adjusted the concentrator knob down to 2 L/min. The resident denied adjusting her oxygen settings and stated, I don't mess with it. On 9/18/24 at 4:50 PM, the DON said the nurse should check the oxygen settings every time they went into a resident's room to ensure they were getting it as ordered by the physician, so they get the proper care. Review of the facility's policy and procedure for Oxygen Therapy dated 11/30/24 read, In the event a resident requires the use of oxygen to manage a medical condition, The Company will offer assistance as ordered by the resident's physician .Procedure: 1. The nurse will organize the oxygen therapy as ordered by the resident's physician Adjust the flow of oxygen as ordered by the physician .