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	12/10/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on interview, and record review, the facility failed to ensure staff reported allegations related to an incident of alleged verbal abuse of a resident by a staff member in a timely manner for 1 of 3 residents reviewed for abuse/neglect/exploitation, (#1). Findings: Resident #1 was initially admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke) due to embolism of left middle cerebral artery, aphasia (inability to speak), generalized anxiety disorder, and recurring major depression. Resident #1's Quarterly Minimum Data Set assessment dated [DATE] revealed he had a Brief Interview of Mental Status score of 12 out of 15 which indicated moderate cognitive impairment. He presented with depressed moods for several days during the two week look back period and did not exhibit any behaviors of rejection of care or physical and verbal violence towards others. Resident #1 had upper and lower extremity functional limitations in range of motion to the right side of his body. He required setup/clean-up assistance for eating and oral hygiene and supervision/touch assistance for showers, toileting, dressing, and personal hygiene but was independent for mobility. Review of the facility's reportable/adverse incidents from September- November 2024, revealed that on 11/21/24 the facility reported alleged verbal abuse towards resident #1 by Licensed Practical Nurse (LPN) A. The report indicated that on 11/20/24 at around 10:00 PM, LPN A was heard by witnesses yelling in resident #1's room. When they came out of the room the resident was visibly upset and attempting to tell LPN A something regarding his medications. The report detailed LPN A said that resident #1 punched her on the abdomen while they were in the room and then she was overheard telling the resident that if it wasn't for her going to jail, she would punch him in the [expletive] face. The incident report indicated resident #1 was taken to his room by Certified Nursing Assistant (CNA) D and Registered Nurse (RN) C. LPN A continued working with resident #1 and staff failed to report the incident until the end of the shift. The report showed LPN A reported the incident to the Staffing Coordinator prior to leaving the facility, over nine hours later. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #1's daily progress notes revealed on 11/20/24 at 10:00 PM, LPN A documented that resident #1 punched her in the abdomen and was visibly upset and angry, but it was unclear to her why he had behaved in that manner when she attempted to obtain his vitals. She wrote that prior to obtaining the vitals the resident appeared pleasant and agreeable, but he had difficulty expressing himself and became angry when not understood. She indicated the resident was removed from the area by a CNA and taken to his room. On 12/09/24 at 1:00 PM, resident #1 was interviewed in his room while he was sitting up in his wheelchair. When asked about the incident that occurred on 11/20/24 with LPN A he became very upset and was unable to verbally explain what happened because of his speech impediment but he attempted to act it out. He was sat by the right side of the bed next to the window and then wheeled himself around to the left side of the bed and transferred into his bed to show that he was in bed when LPN A came into his room. He transferred back into his wheelchair and wheeled out of the room to the hallway where there was a nurse at a medication cart next to his room. He started to bang loudly on the medication cart and pointed to the nurse. The nurse asked him if he was attempting to explain what happened with LPN A and he shook his head in agreement. She said he was still very upset about the situation, but she was unsure of the whole story. Resident #1 wheeled himself back into his room and nodded in agreement that LPN A had cursed at him and he hit had her. He had a book with pictures and words next to his bed and he pointed to a page that said that his cognition was intact, but he just could not talk. Then he flipped to another page where he pointed at a sad face. On 12/09/24 at 4:10 PM, in an interview with LPN A via telephone, she confirmed that she was resident #1's assigned nurse on 11/20/24. She said that around 10:00 PM on 11/20/24 resident #1 was due for his blood pressure medication so she entered his room with the medication and a blood pressure machine. His blood pressure was low, so she was going to hold the medication and then the resident got frustrated because she did not have the rest of his medication. Due to his speech impediment, she was unable to understand what he had said but she thought he was asking for the rest of his medications. She said that she administered his other two medications and then attempted to get the blood pressure machine that was left in his room. Resident #1 punched her on the abdomen, and she left the room upset but not seriously injured. She said that she cursed at the resident and told him that she would call the cops on him for hitting her. She explained the resident was out in the hallway when she cursed at him, but said she did not see any staff around. She said that she chose to give the resident his medications last, and she knew that he preferred to have them earlier so that had probably made him upset. She did not immediately report the incident to her Supervisor but instead waited until the end of her shift to report it to the Staffing Coordinator. She said she had received education on reporting abuse/neglect previously on 10/20/24 and was aware that she should have called the On-call Supervisor immediately to report the incident. On 12/09/24 at 4:45 PM, CNA D said that on 11/20/24 at around 10:00 PM, she was at the nurse's station on the North Wing when she saw resident #1 and LPN A coming out of his room. CNA D recalled LPN A was screaming that he had punched her on the abdomen. CNA D said that the resident was pointing at the medication cart that was by his room and putting up three fingers. She expressed that resident #1 looked very upset with LPN A and overheard her say that if it wasn't for her going to jail she would [expletive] punch him in the face. She said that he was probably upset because LPN A gave him his medications later than he preferred, and he could not tell her due to his speech impediment. She said she assisted the resident back to his room and got him to calm down before putting him to bed. CNA D said that the incident could be considered abuse because LPN A cursed at the resident, but she did not immediately report it because she thought it was LPN A's responsibility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/09/24 at 5:53 PM, CNA B said she had worked on the North Unit on 11/20/24 and overheard the commotion with LPN A and resident #1. She explained that she witnessed LPN A cursing at resident #1 and saw that he was very upset. She said she did not report it to a Supervisor because she expected that LPN A would do that. She said she had received abuse/neglect training in the past and was told that she should report suspected abuse/neglect to a Supervisor as soon as possible. On 12/09/24 at 6:30 PM, RN C stated that she had worked on the North Unit on 11/20/24 and was passing medications down the hallway from resident #1's room. She overheard LPN A screaming for help because resident #1 had punched her in the stomach. She said that other CNAs were attempting to take him to his room and LPN A continued to pass medications but did not report the incident. RN C said she did not report the incident to her Supervisor because LPN A should have done it. She confirmed she had received abuse/neglect training in the past and was told that they must report any allegations of abuse/neglect to their Supervisor as soon as possible. On 12/10/24 at 3:52 PM, the Director of Nursing (DON), Administrator, and Regional Nurse Consultant (RNC) were jointly interviewed regarding the incident and abuse/neglect training. The DON stated that during the morning clinical meeting on 11/21/24 she was informed by the Staffing Coordinator of the incident. She confirmed she had not received a call from LPN A or any other staff members on the night of 11/20/24. She spoke to the resident during the investigation, and he was upset because LPN A gave him his medications late and he was also frustrated. The DON said LPN A was suspended pending the investigation because witnesses heard her cursing at the resident. She said that all staff received abuse/neglect training upon hire, annually, and after any allegations of abuse/neglect. She confirmed that all staff were educated on being mandatory reporters and to report any incidents to their immediate Supervisor, DON, or the Administrator within 2 hours per facility policy. The Administrator said that the expectation was for staff to report all incidents to their Supervisor on site or via phone within 2 hours of occurrence. Review of the facility's policies and procedures titled Abuse, Neglect, Exploitation, and Misappropriation, revised 11/16/22, revealed that verbal abuse may be considered a form of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance regardless of age, ability to comprehend, or disability. Verbal abuse could include mocking, insulting, yelling, or hovering over a resident with intent to intimidate. Employees were trained that if they witnessed or had knowledge of an act of abuse or allegation of abuse, neglect, exploitation, or mistreatment they must report the information immediately, but no later than two hours after the allegation was made. An employee would be deemed to have violated their obligations if they failed to report an incident of abuse that was witnessed or reported to them.

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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 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** 49840 Based on interview, and record review, the facility failed to develop, implement, and revise the person-centered comprehensive care plan to ensure it met their preferences, goals, and addressed their medical, physical, mental and psychosocial needs, for 1 of 2 residents reviewed for changes in behavior, of a total sample of 3 residents, (#3). Findings: Resident #3 was admitted to the facility on [DATE] with diagnoses that included a wedge compression fracture of unspecified lumbar vertebra, Parkinson's Disease, adult failure to thrive, and cognitive communication deficit. He was discharged from the facility on 11/25/24 due to family request to take him to a different state. Resident #3's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed he had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated severe cognitive impairment. The assessment revealed he did not exhibit any physical or verbal behaviors towards others and did not have any wandering behaviors. Review of the discharge MDS assessment completed on 11/25/24, revealed a different BIMS score of 3 out of 15,and included disorganized thinking continuously without fluctuations, wandering behaviors, and other behaviors such as pacing, rummaging, and disrobing in public. He was independent for all activities of daily living and had no functional limitations. Review of resident #3's medical record revealed he had an order for a electronic wander bracelet placed on 11/01/24 that was to be checked daily. Review of the facility's reportable/adverse incidents from September- November 2024, revealed a report of an alleged resident to resident abuse involving another resident and resident #3. According to the report on 11/18/24 at approximately 1:00 AM a nurse reported to the On-call Supervisor that resident #3 had entered another resident's room and was observed by staff attempting to pull this resident out of bed by her wrist to take her to the shower. According to witness statements resident #3 was not wearing any clothing except for a blanket around him. The staff reported they took resident #3 to his room and then completed an assessment on both residents. The facility's immediate response to the event was to place resident #3 with a one to one sitter, notification to family and physician, and a referral for psychological evaluation. Review of resident #3's care plan initiated 11/01/24 revealed he had wandering behaviors related to entering other residents' rooms naked. Interventions revised 12/10/24, after the resident had been discharged , included monitoring the electronic wander bracelet for placement, and redirecting the resident to other activities. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 12:37 PM, the MDS Coordinator said that she was one of the people responsible for creating and updating the care plans. She said that during Inter Disciplinary Team (IDT) meetings she would be informed of any changes with the residents and then she would go to the unit to complete an assessment. The care plan was generated by the resident assessments, physician orders, resident preferences, and any other information received by the staff. She said that she found out that resident #3 wandered into another resident's room during the morning meeting on 11/18/24 and was aware that he had wandered into other resident rooms in the past but had not attempted to get them out of bed. She explained he had a care plan for wandering behaviors that had been initiated after he wandered into a resident's room for the first time after admission. She said that after his second and third incident of wandering into female resident's rooms, no revisions to the care plan interventions had been made in response to the continued behaviors. On 12/10/24 at 12:04 PM, the Director of Nursing (DON) confirmed that resident #3 had wandering behaviors and had been reported by two female residents in the past because he entered their room. She expressed an electronic wander bracelet was ordered after the first incident, and a care plan was initiated. She confirmed after the second instance, the care plan interventions were not revised and after the third instance he was put on a one to one sitter but said the care plan was not updated because the family would be taking the resident home. The DON said the resident was discharged on [DATE]. She said that the expectation was for the IDT team to discuss care plan interventions and determine their effectiveness. Review of the facility's policies and procedures on Plans of Care revised 9/25/17, revealed that an individualized person-centered plan of care would be established by the IDT team with the resident and/or resident representatives to the extent practicable and updated in accordance with state and federal regulatory requirements. The care plan must be reviewed, updated, and revised based on the resident's changing goals, preferences, and needs. The care plan may include services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as well as individualized interventions and alternative services that honor the resident's preferences.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49840 Based on interview, and record review, the facility failed to maintain medical records that were complete and accurately documented related to missing and incomplete documentation of a reportable incident for 2 of 3 sampled residents, (#2, and #3). Findings: Review of the facility's reportable/adverse incidents from September- November 2024, revealed a report of alleged resident to resident abuse involving resident #2 and #3. According to the report on 11/18/24 at approximately 1:00 AM, a nurse reported to the On-call Supervisor that resident #3 had entered resident #2's room and was observed by staff attempting to pull resident #2 out of bed by her wrist to take her to the shower. According to witness statements resident #3 was not wearing any clothing except for a blanket around him. The report indicated staff took resident #3 to his room and then completed an assessment on both residents. Resident #2 was found to have slight redness on her wrist with no other visible injuries and she expressed to the nurse that she was not afraid of resident #3 but was not intending to go with him. The facility's immediate response to the event was to complete a skin assessment on resident #2, place resident #3 with a 1 to 1 sitter, notification of the event to family and physician, and a referral for psychological evaluation. Review of resident #3's medical record revealed that on 11/18/24 a progress note had been entered by the Social Service Director (SSD) that documented that resident #3's wife had been informed about an alleged physical abuse allegation he was involved in with resident #2. There was no documentation detailing the event or the immediate care that was provided to the resident post incident. Resident #2's medical record revealed that there were no progress notes entered on 11/18/24 that detailed the event, any assessments that were done, or any notification to the family and doctor. The record indicated she was seen by the Advanced Practice Registered Nurse related to a fall that she sustained on 11/19/24 but there was no mention of the abuse allegation incident. A psychiatric evaluation was completed on 11/21/24 as part of the new admissions process but there was no mention of the abuse allegation. Review of the assessments that were done on 11/18/24, revealed that a weekly skin assessment was completed on 11/18/24 at 5:37 PM, over 17 hours after the abuse allegation, with no documentation of the redness that had been reported by the nurse who assessed her immediately after the incident. On 12/09/24 the Director of Nursing (DON) provided a paper copy of a skin observation assessment that she completed on resident #2 dated 11/18/24 with no time documented. According to the DON this assessment had been completed as part of the investigation but not immediately after the incident. She confirmed there was no documentation of a skin assessment immediately after the incident. On 12/09/24 at 6:30 PM, Registered Nurse (RN) C said that she was the nurse who responded to resident #2's room during the early morning hours on 11/18/24. She said that she observed resident #3 attempting to pull resident #2 out of bed by her wrist and assisted in getting him out of the room. She said that she completed an assessment of resident #2 and noticed some redness to her wrist but no other injury was noted. She provided the assessment information to the On-call Supervisor but confirmed she did not document in the resident's medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 2:51 PM, the SSD stated that she started working at the facility on 10/30/24 and was delayed in receiving access to document in the facility's electronic medical record system. She provided a copy of a note typed in plain white paper that was dated 11/18/24 but had no time. The note regarded a visit to resident #2's room to follow up on the incident that occurred the night prior with another resident. According to the facility, the incident occurred in the early morning hours of 11/18/24. The SSD stated in the note that the resident's daughter was at the bedside, and she informed the daughter of what had happened. The SSD said that during an investigation of alleged abuse, she was responsible for completing an initial psychosocial assessment of the resident and then following up for three days or more as needed. She confirmed that by 11/18/24 she already had access to the electronic medical record but chose to type her notes on a word document. She said that the psychosocial assessment that was completed on 11/18/24 had been started on 11/16/24 as part of the resident new admission assessment and not related to the incident. She was unable to provide documentation of the follow up visits that she completed with resident #2 regarding the incident. On 12/10/24 at 12:04 PM, the DON stated that her expectation was for staff to document any changes in resident condition, interactions with family, or incidents prior to the end of their shift. She said the progress note should have a brief explanation of any incident involving the resident. Review of the facility's policies and procedures regarding clinical/medical records revised on 8/25/17, revealed that the purpose of the clinical record was to document the course of the resident's plan of care and to provide a medium of communication among health care professional involved in their care. The clinical record must contain a record of the resident's assessments, the plan of care and services, and progress notes that indicate changes towards achieving care plan goals.