STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105895	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024
NAME OF PROVIDER OR SUPPLIER: Aspire at Seminole		STREET ADDRESS, CITY, STATE, ZIP CODE: 9393 Park Blvd Seminole, FL 33777	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441 Based on interview and record review, the facility failed to investigate an injury of unknown origin that resulted in a transfer to a higher level of care for one (#1) of one resident out of ten residents reviewed. Findings Included: A review of Resident #1's Admission Record showed an original admitted [DATE] with a readmitted [DATE] with the following diagnoses: Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side Other abnormal of gait and mobility Need for assistance with personal care Difficulty in walking, not elsewhere classified. Muscle weakness (generalized) Muscle wasting and atrophy, not elsewhere classified, unspecified site A review of Resident #1's care plan dated [DATE] showed a Focus area: ADL (Activity of Daily Living)/ self-care performance deficit related to hemiparesis, weakness, dementia, schizoaffective disorder-depressive type, major depressive disorder, insomnia, incontinence, muscle wasting and atrophy, lumbar spondylosis impaired mobility. Interventions include but are not limited to: Bed Mobility: The resident requires moderate to max assistance by one staff to turn and reposition in bed frequently and as necessary. (revised on [DATE]) Transfer: The resident requires total assistance by two staff to move between surfaces and as necessary. (revised on [DATE]) (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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:23 p.m., an interview was conducted with Staff H, Registered Nurse (RN). Staff H stated Resident #1 was assigned to her on [DATE]. Staff H stated Resident #1 told her he was dropped when getting out of bed earlier. Staff H stated the resident told her this information while his daughter was in the room. Staff H stated the resident told her he fell from his bed to the wheelchair. Staff H stated she was in shock because no one told her. Staff H stated she immediately interviewed the resident and did a full head to toe assessment with vital signs. Staff H stated she then talked to the two Certified Nursing Assistants (CNA) responsible for his transport from the bed to the wheelchair and both denied he fell . Staff H, RN could not name the two CNAs but would recognize their faces. Staff H stated she filled out an incident report and immediately notified the nurse practitioner and the Director of Nursing. Staff H stated the daughter was at his bedside the whole time and was witness to the resident's statement of the events. Staff H stated earlier Resident #1 requested to eat his dinner out of bed that evening. Staff H stated she requested the CNA assigned to the resident to assist with his request. Staff H stated she was finishing her medication administration when Resident #1's daughter approached her at the nurses' station and stated the resident wanted to return to bed due to pain. Staff H stated she did not see the daughter initially enter the facility. Staff H stated the resident was transferred to the wheelchair ten to fifteen minutes prior to his request to return back to bed. Staff H approached Resident #1 in the TV room and offered pain medication but stated he wanted to return to bed. Staff H stated she personally returned the resident back to his bed with his assigned CNA via a mechanical lift. Staff H stated the resident appeared more comfortable once he returned to his bed but was unable to straighten both his legs. Staff H stated she gave Resident #1 [Acetaminophen] and stated the resident had received stronger pain medication earlier and it was too soon to receive another dose. Staff H notified the nurse practitioner regarding the resident's increased pain and the daughter's concern to have the resident transferred to the hospital for further evaluation. On [DATE] at 3:03 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated she received a call from Staff H on the night Resident #1 went to the hospital after his claim of a fall. The DON stated the nurse in her incident report stated the resident told her he fell while transferring to his wheelchair with two CNAs. The DON stated the CNAs were not interviewed by her but went by the incident report filled out by Staff H. The DON stated Resident #1 should be transferred via mechanical lift by two nursing staff. The DON could not state who the two CNAs were or confirm how the resident was transferred to the wheelchair. The DON stated the resident had a fall on [DATE] in which x-rays and pain medication were ordered. The DON stated the resident was normally confused and stated she thought the resident was confused on [DATE] as the fall he experienced was on [DATE]. The DON stated falls were discussed the following day during the interdisciplinary (IDT) team meeting. The DON stated the resident had expired at the hospital. On [DATE] at 3:45 p.m., an interview was conducted with Staff I, CNA. Staff I stated Staff H asked her to get Resident #1 out of bed into his wheelchair. Staff I stated she used a [sit to stand] to transfer the resident with the assistance of Staff J, CNA. Staff I stated Resident #1 acted scared of the sit and stand but did good transferring to wheelchair. Staff I stated she brought the resident to the TV room. Staff I stated she saw the resident's daughter with him. Staff I stated the resident was complaining of pain all day. Staff I stated he was out of bed for 10 minutes before Staff H asked for assistance to return the resident back to bed. Staff I stated the resident did not fall when she assisted resident initially out of bed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 4:00 p.m., an interview was conducted with Staff J. She stated she did not assist getting Resident #1 out of bed but simply held the wheelchair steady while Staff I transferred the resident to the wheelchair from a standing position. Staff J stated the resident was able to weight bear and Staff IF stood the resident up and transferred him into the wheelchair in a stand and pivot motion. Staff J stated, all I know was he was in a lot of pain all day. On [DATE] at 4:14 p.m., an interview was conducted with Staff F, Director of Clinical Services (DCS), Staff E, Regional [NAME] President of Operations (VPO) and the DON. Staff F, DCS stated in a change of condition such as a fall, the priority is the resident. Staff F stated the resident should initially be assessed head to toe for any injuries. The physician and family representative should be notified. Staff F stated during morning IDT rounds, any incident(s) were reviewed. If there were any questions, we would potentially get more interviews to close the loop of the concern. Staff F stated if the resident went to a higher level of care, a root cause analysis would involve interviewing the staff. Staff E, VPO stated the Admissions department would follow up with a resident that was transferred to a higher level of care. Staff E was unable to state the outcome of Resident #1 but went to the Admissions department, returned, and stated Resident #1 had expired the following day. A review of Resident #1's hospital record dated [DATE] showed a history and physical of Resident #1: [AGE] year-old male presents today with apparent pain to bilateral lower extremities. It was noted today that patient does not want to extend either knee and seems agitated with any attempts to passively extend. Seems to complain of pain of lower extremities but patient has difficulty relating history due to history of dementia. A review of Resident #1's re-evaluation dated [DATE] and timed at 22:00 (10:00 a.m.) showed a reevaluation status notation: [AGE] year-old presents today with apparent pain to bilateral extremities their hematoma suggestive of possible injury. Reevaluation status: bilateral knee fractures. A review of Resident #1's radiological results of left and right knee showed the following: Left knee: Impacted proximal fibular metaphyseal fracture of indeterminate age. Left knee: Nondisplaced proximal tibial metaphyseal fracture of indeterminate age. Right knee: Acute comminuted proximal tibial metaphyseal fracture. Right knee: Age indeterminate proximal fibular metaphyseal fracture. A review of the facility's policy titled, Florida Adverse Incident Reporting, revised [DATE] showed the following policy statement: The Facility will be in compliance with State Adverse incident reporting requirements. The Administrator and/ or designated risk manager are responsible for the state reporting. Adverse incident reports will be submitted as required by state regulations for events meeting reporting criteria. The policy's procedure includes but is not limited to: 1. The facility will file an adverse incident report for events meeting reporting criteria. 2. The purposes of reporting to the agency under this requirement, the term adverse incident means: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a) An event over which the facility personnel could exercise control and which is associated in whole or in part with the facilities intervention, rather than the condition for which such intervention occurred, and which results in one of the following: 1) Death 2) Brain or spinal damage 3) Permanent disfigurement 4) Fracture of dislocation of bones or joints 5) A limitation of neurological, physical, or sensory function 6) Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives 7) Any condition that requires the transfer of the resident, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the resident's condition prior to the adverse incident; or, 8) An event that is reported to law enforcement or its personnel for investigation

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49227

Based on observations, interviews, and record review, the facility failed to 1. provide treatment and services in accordance with physician orders for one (#9) out of three residents reviewed; and 2. failed to ensure call lights were answered within a timely manner for four (#5, #6, #7, and #8) of ten sampled residents.

Findings Included:

1. Review of the Admission Record showed Resident #9 was admitted to the facility on [DATE] with diagnoses to include acute osteomyelitis, chronic ulcer of the right heel and midfoot, peripheral vascular disease, and type 2 diabetes mellitus with foot ulcer.

Review of Resident #9's Medication Administration Record for November 2024 showed the following:

-Cleanse left Achilles with [antimicrobial wound cleanser] 0.125% solution, apply nickel thick [topical enzyme medication] and cover with dry dressing every day shift for arterial wound, completion of wound care was not documented on 11/3, 11/4, 11/5, 11/6, and 11/9/2024.

-Cleanse left anterior lower leg with [antimicrobial wound cleanser] 0.125%, apply nickel thick [topical enzyme medication] and cover with dry dressing every day shift for arterial wound, completion of wound was not documented on 11/3, 11/4, 11/5, 11/6 and 11/9/2024.

- Cleanse left dorsal foot with [antimicrobial wound cleanser] 0.125%, cover with nickel thick [topical enzyme medication] and dry dressing every day shift for arterial wound, completion of wound care was not documented on 11/3, 11/5, 11/6 and 11/9/2024.

-Cleanse left great toe with NS apply Betadine leave open to air (OTA) every day shift for arterial wound, completion of wound care was not documented on 11/3, 11/5, 11/6 and 11/9/2024.

-Cleanse left temple with NS, pat dry apply silver sulfadiazine and leave OTA daily every night shift for wound care, completion of wound care was not documented on 11/14.

-Silva sulfadiazine external cream 1% apply to left temple topically every night for infectious wound cleanse wound with [antimicrobial wound cleanser] leave OTA, completion of wound care was not documented on 11/14/2024.

-Cleanse left great toe with NS apply Betadine leave OTA every day shift for arterial wound, completion of wound care was not documented on 11/22 and 11/24/2024.

-Cleanse left Achilles with Normal Saline (NS), pat dry, apply nickel thick [topical enzyme medication], cover with silver (Ag+) alginate and cover with dry dressing every day shift for arterial wound, completion of wound care was not documented on 11/22 and 11/24/2024.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/24 at 1:20 P.M., Resident #9 was observed lying in bed, after obtaining permission, Staff K, Certified Nursing Assistant (CNA) assisted with exposing the dressing on his left lower extremity. The dressing was dated 7A-7P, 11/23. Review of Resident #9's care plan focus showed, diabetic ulcer on the left lateral foot, initiated 9/18/24, interventions included administer treatment as ordered. During an interview on 11/25/2024 at 3:30 P.M., the Director of Nursing said the facility's expectation was that dressings were to be dated and initialed by the nurse. Review of a facility's policy and procedure, titled Clinical Guideline Skin and Wound, effective date 4/1/2017 showed Overview: To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/ prevention of pressure injury. Process: .develop individualized goals and interventions Review of facility's policy and procedure, titled Physician Orders, effective date 11/30/2024 showed Policy: The center will ensure that physician orders are appropriately and timely documented in the medical record. 20536 2. On 11/25/2024 during the 7-3 shift, the facility was toured and the following call light observations were made: On 11/25/2024 at 9:26 a.m., Resident #5's call light above the room door was observed on. There were various staff walking by the room to include Certified Nursing Assistants, Nurses, and Housekeeping staff. At 9:34 a.m., a staff member went into the room to answer the light. It was noted the call light was on for at least eight minutes without staff responding to it. On 11/25/2024 at 10:00 a.m., an interview with Resident #5 revealed call lights were routinely answered late and there were times it took over thirty minutes before someone answered. She also revealed there were times when staff came in just to turn off the light and would leave without finding out what she needed. She revealed this happened during the days, nights, and weekends. Review of the current Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed, Cognition - Brief Interview for Mental Status (BIMS) score was 10 of 15 which indicated the resident had moderate cognitive impairment. On 11/25/2024 at 10:20 a.m., Resident #6's call light above the room door was observed on. There were various staff walking by the room to include Certified Nursing Assistants, Nurses, and Housekeeping staff. At 10:28 a.m., a staff member went into the room to answer the light. It was noted the call light was on for at least eight minutes without staff responding to it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/2024 at 10:40 a.m. Resident #6 was interviewed with relation to call light response times. She confirmed her light was just answered untimely and it happened a lot. She revealed there were times when her call light was not answered for over twenty minutes. She had mentioned this to staff but there had not been any changes. Review of the current Quarterly MDS assessment dated [DATE] showed, Cognition - BIMS score - 12 of 15 which indicated the resident had moderate cognitive impairment. On 11/25/2024 at 12:20 p.m., Resident #7's call light above the room door was observed on. There were various staff walking by the room to include Certified Nursing Assistants, Nurses, and Housekeeping staff. At 12:32 p.m., a staff member went into the room to answer the light. It was noted the call light was on for at least twelve minutes without staff responding to it. On 11/25/2024 at 1:30 p.m., an interview with Resident #7 was attempted. She was noted with cognition deficits, but was able to answer simple questions related to her call light response times. She confirmed she used the call light and there were times staff do not answer the lights for over thirty minutes. She had reported this concern to staff (unnamed) in the past. Review of the current Quarterly MDS assessment dated [DATE] showed, Cognition - BIMS score was 9 of 15, which indicated the resident had moderate cognitive impairment. On 11/25/2024 at 11:50 a.m., Resident #8's call light above the room door was observed on. There were various staff walking by the room to include Certified Nursing Assistants, Nurses, and Housekeeping staff. At 12:06 p.m., a staff member went into the room to answer the light. It was noted the call light was on for at least sixteen minutes without staff responding to it. On 11/25/2024 at 1:00 p.m., an interview with Resident #8 revealed she had made complaints related to staff call light response times. She revealed there had been times the call light had not been answered for over one hour. She revealed this happened during the nights mostly, but there were times during the days when the call light had not been answered timely. Review of the current Annual MDS assessment dated [DATE] showed, Cognition - BIMS score was 11 of 15, which indicated the resident had moderate cognitive impairment. On 11/25/2024 at 12:00 p.m., an interview with the 100/200/300 Unit Manager confirmed that all residents, while they were in their room either in a chair or in bed, were to have the call light placed within their reach. She further revealed that all staff were qualified to answer a call light initially. The Unit Manager revealed the expectation was for staff to answer the call light as soon as possible. The Unit Manager was asked if answering call lights ranging from eight minutes to sixteen minutes was an expectation. She revealed that the lights should be answered in a manner that was more timely. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/2024 at 12:45 p.m. - 1:10 p.m., Staff A and Staff C, Certified Nursing Assistants (CNAs), and Staff B, Registered Nurse (RN) revealed all residents while in their rooms were placed with a call light within their reach. Staff A, C, and B revealed that call lights were to be answered as soon as they saw the light on and to be answered as soon as possible. Staff A and Staff C revealed when they answered call lights, they were to go in the room and find out what the resident needed and then to assist that resident, rather than just go in the room to turn off the light and leave the room. Staff A, B, and C also revealed sometimes during the shift, things could be busy and it could take some time to answer the light. However, they said any staff member could walk to the room to at least find out what was needed initially. On 11/25/2024 at 5:00 p.m., an interview with the Staff E, Regional [NAME] President of Operations, and Staff F, Director of Clinical Services revealed call lights were to be answered as soon as possible but there could be some parts of the day when they staff were busy like during meal pass, and lights could take a little longer to answer. Both Staff E and F confirmed call light response times ranging from eight minutes to sixteen minutes was not timely. Staff were routinely trained and inserviced on the importance of answering call lights right away. The Nursing Home Administrator of record was not available for interview during the time of the survey. Staff E revealed the facility did not have a specific policy and procedure related to call light response times.