

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 05/23/2024
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498</p> <p>Based on observation, record review, and interview, the facility failed to ensure a dignified existence was provided to one resident (#16) out of eight residents sampled.</p> <p>Findings included:</p> <p>During an observation made on 05/20/2024 at 2:51 p.m. Resident #16 was observed scooting around on the floor in her room with staff surrounding her. The resident scooted from her room into the middle of the hallway in front of other residents and staff.</p> <p>During an observation made on 05/22/2024 at 10:30 a.m., in the activities room, Resident #16 was observed in a corner separated from other residents in the activities room while an activities program was being conducted with other residents. She was observed sleeping with a blanket over her whole body, reclined back in the chair's lowest position and her feet positioned upward.</p> <p>Review of an Admission Record, dated 05/23/2024, showed Resident #16 was admitted originally on 05/18/2022 and readmitted on [DATE] with diagnoses to include senile degeneration of brain, not elsewhere classified, chronic obstructive pulmonary disease, unspecified, bipolar disorder, current episode mixed, severe, with psychotic features.</p> <p>Review of a Minimum Data Set (MDS), Assessment Reference Date/Target Date 02/19/2024, showed a Brief Interview for Mental Status (BIMS) score of 03 which indicated Resident #16 was severely impaired.</p> <p>Review of Resident #16's care plan, initiated 05/19/2022 and revised on 05/20/2024, showed a focus area as the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (related to) cognitive deficits, and the resident had a history of falls, dementia, bipolar disorder, anxiety disorder, cataracts. The care plan goals documented, [Resident #16] will maintain involvement in cognitive stimulation, social activities as desired through review date. Date initiated 05/19/2022 and revised on 10/30/2024. The target date for this goal was 06/02/2024. The interventions for this care plan included to ensure the activities the resident is attending are Compatible with physical and mental capabilities; Compatible with known interests and preferences; Adapted as needed (such as large print, holders if resident lacks hand strength; task segmentation), Compatible with individual needs and abilities; and Age appropriate. Date initiated: 05/19/2022.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/20/2024 at 3:00 p.m. an interview was conducted with Staff A, License Practical Nurse (LPN). She stated Resident #16 was care planned to put herself on the floor. She said she would assist the resident off the floor in a few minutes.</p> <p>On 05/22/2024 at 11:00 a.m. an interview was conducted with the Activities Director. She stated that she was used to Resident #16 being placed in the activity room so she could watch her during activities. She said the resident was sleeping. She was not able to recall who placed the resident in the activity room.</p> <p>On 05/22/2024 at 11:00 a.m. an interview was conducted with the Director of Nursing (DON). She stated Resident #16 should not have been left in the activity room the way she was. She would have expected her staff to put the resident back in her bed. She further stated staff should not allow the resident to scoot out in the hallway. Someone should have assisted her off the floor.</p> <p>On 05/22/2024 at 3:00 p.m. an interview was conducted with the Nursing Home Administrator (NHA). She stated the way Resident #16 was found in the activity room was unacceptable. She said someone should have put the resident in her bed if she was asleep.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498</p> <p>Based on observation, record review and interview, the facility failed to ensure a reasonable accommodation of resident needs for one resident (#44) out of eight sampled residents related to having an appropriate bed to sleep in.</p> <p>Finding included:</p> <p>During an observation made on 5/20/2024 at 12:00 pm. Resident #44 was observed lying down in bed with his feet hanging off the edge of the bed mattress. He was observed dressed in his night gown. He said his legs were too long for his bed and the staff at the facility had known about it for a long time, but had not done anything about it.</p> <p>During an observation on 5/22/2024 at 8:00 a.m. Resident #44 was observed lying down in bed with his head slightly elevated and his feet hanging off the edge of his bed. He said he would like to have another bed because he was not able to fit on his bed.</p> <p>Review of an Admission Record, dated 5/22/2024, showed Resident #44 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses to include but not limited to difficulty in walking, not elsewhere classified, schizoaffective disorder, depressive type, depression, unspecified.</p> <p>Review of a Minimum Data Set (MDS) with an Assessment Reference Date of 4/26/2024 showed a Brief Interview for Mental Status (BIMS) score of 06, which indicated the resident was severely cognitive impaired.</p> <p>During an interview on 5/20/2024 at 3:00 p.m. with Staff B, Certified Nursing Assistant (CNA), she stated she worked at the facility for six years. She said Resident #44 has had the air mattress he was on for a long time. The mattress was not a good fit for him because his legs were too long. He had complained about it, but nothing had been done.</p> <p>During an interview on 5/23/2024 at 8:11 am. with the Assisted Director of Nursing (ADON), she stated she worked as the ADON since February 26, 2024. She said she reviewed Resident #44's chart and noticed that he had a wound, but it was resolved. She stated she really did not know why he still had an air mattress because it should have been switched out for a regular mattress. She did not think the resident's mattress was a problem because she had not had anyone complain to her about it.</p> <p>During an interview on 5/23/2024 at 8:11 a.m. with the Director of Nursing (DON), she stated the facility process was on admission, if a resident had a wound, then the Admission Coordinator would notify the interdisciplinary team that special equipment was needed for the resident, for example an air mattress. She stated, When I reviewed [Resident #44's] record he did not currently have a wound, so there is no purpose for him to have an air mattress at this time. We do not measure residents when providing them with a mattress. My expectation is that staff notify us if a resident bed is too small, or they can put the information on the maintenance log so we can review it there. We saw the resident's mattress today and we will remove it immediately and replace it with a mattress appropriate for him. She said I would have expected the CNA to report this information to her.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/23/2024 at 3:11 p.m. with the Regional Nurse Consultant, she said they did not have a policy regarding mattress sizing or accommodation of needs related residents' beds. This situation was a standard of care. The CNA should have notified their nurse, or the concern should have been logged in the maintenance logbook. They were always told to tell someone if they identify an issue with their residents.</p> <p>Photographic evidence obtained.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015</p> <p>Based on record review, interview, and review of the facility's policy Preadmission Screening and Resident Review (PASRR), the facility failed to ensure residents received an accurate Level I Preadmission Screening and Resident Review (PASRR) for four residents (#6, #68, #36 and #43) of twenty-three sampled residents who were reviewed for PASRR screens.</p> <p>Findings included:</p> <p>1. Review of the Admission Record showed Resident #43 was admitted to the facility on [DATE] with diagnoses that included but not limited to undifferentiated schizophrenia, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and major depressive disorder, recurrent.</p> <p>Review of the Aging Solution Form, dated 04/15/24, showed under the Diagnosis and Active Diagnoses section Resident #43 had a Primary Diagnosis Dementia; Secondary Diagnosis Traumatic Brain Injury.</p> <p>Review of the Admission Minimum Data Set (MDS), dated [DATE], showed in Section C - Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 09 (moderate cognitive impaired). Under Section I - Active Diagnoses Non-Alzheimer's Dementia was marked Yes.</p> <p>Review of a psychological progress note, dated 04/25/24, showed Resident #43 had diagnoses (DX) of Unspecified Dementia without behavioral disturbance (active), Undifferentiated Schizophrenia (active), Major depressive disorder, recurrent (active) and Alcohol abuse, uncomplicated (active).</p> <p>A review of Resident #43's Level I PASRR assessment, dated 04/18/22, showed under the section titled Section II: Other indications for PASRR Screen Decision Making the checkboxes for the selections 5. Primary Diagnosis of Dementia, 6. Secondary diagnosis of Dementia and 7. Validating documentation to support dementia or related neurocognitive disorder were marked No in the check boxes.</p> <p>During an interview on 05/22/24 at 4:35 p.m. the Assistant Director of Nursing (ADON) stated both she and the Social Services Director (SSD) were responsible for updating and ensuring PASRRs were completed correctly upon residents' admission. The ADON stated, when a resident came into the facility, we updated the PASRR if there were any discrepancies with a resident's current diagnosis and what was marked on the PASRR. The ADON was asked, based on the information for Resident #43's diagnoses, if dementia should be noted on the PASRR. The ADON stated that she could not give an answer to that question and that she would have to discuss that with the SSD first because they do the PASRRs together.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/22/24 at 4:45 p.m. the Social Services Director (SSD) stated that she was also responsible for the accuracy of PASRRs. The SSD stated she reviewed all admission paperwork and the facility's facesheet to determine what was accurate for the PASRR. The SSD stated she would not mark dementia on Resident #43's PASRR because it was not his primary diagnosis on the facility's facesheet. The SSD stated she had training on PASRRs, but stated she forgot the details of the training and was not sure if dementia should be marked or not. The SSD stated, I am not clinical, I can only go with what clinical puts in. The SSD stated, if it did not say dementia as a primary diagnosis on the facesheet, I will mark no.</p> <p>During an interview on 05/23/24 at 4:42 p.m. the Nursing Home Administrator stated the Aging Solutions Form was received when Resident #43 was accepted into the facility at admission and was from Resident #43's State appointed legal guardian.</p> <p>48441</p> <p>2. Review of the Admission Record showed Resident #68 had an admitted [DATE] with a primary diagnosis of panic disorder [episodic paroxysmal anxiety] with secondary diagnoses of anxiety, insomnia, major depressive disorder, and unspecified psychosis not due to a substance abuse or known physiological condition.</p> <p>A review of the PASRR Level I for Resident #68, dated 7/12/2022, did not have items checked for mental illness/diagnoses.</p> <p>A review of the Minimum Data Set (MDS), dated [DATE] (Quarterly), Section I- Active Diagnoses documented Resident #68 with anxiety, depression (other than bipolar), psychotic disorder (other than schizophrenia), primary insomnia, and unspecified symptoms and signs with cognitive functions and awareness.</p> <p>A review of Resident #68's psychiatric notes, date of service 5/17/2024, discussed gradual dose reduction (GDR) as not a possibility due to resident may become more unstable. Resident #68 is noted to be on minimal effective dosages of psychotropic medications.</p> <p>A review of Resident #68's medical record revealed and emergency transfer on 3/07/2024 due to the likelihood without care or treatment the individual will cause serious bodily harm to self or others in the near future, as evidenced by recent behavior.</p> <p>On 5/22/24 at 5:00 p.m. an interview was conducted with the Nursing Home Administrator (NHA) regarding Resident #68. The NHA reviewed the PASRR and stated the Level I was not complete regarding diagnoses.</p> <p>3. A review of Resident #6's Admission Record showed an admitted [DATE] with a primary diagnosis of end stage renal disease with secondary diagnoses of bipolar disorder unspecified, unspecified mood [affective] disorder, unspecified depression, generalized anxiety, schizoaffective disorder bipolar type, and homicidal ideations.</p> <p>A review of the PASRR Level I for Resident #6, dated 8/19/2022, did not have items checked for mental illness/diagnoses.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the MDS, dated [DATE] (Quarterly), Section I- Active Diagnoses had Resident #6 with depression, bipolar disorder, schizophrenia, and other symptoms and signs involving appearance and behavior.</p> <p>On 5/22/24 at 5:00 p.m. an interview was conducted with the NHA regarding Resident #6. The NHA reviewed the PASRR and stated the Level One was not complete regarding diagnoses. The NHA stated, I did not see the homicidal ideations for a diagnosis.</p> <p>39438</p> <p>4. A review of the Admission Record showed Resident #36 was initially admitted on [DATE] with diagnoses of bipolar disorder, major depressive disorder, unspecified dementia with psychotic disturbance, mood disturbance, and anxiety, and generalized anxiety disorder.</p> <p>Section I - Active Diagnoses of the Minimum Data Set (MDS), dated [DATE], showed Resident #36 had diagnoses of anxiety disorder and bipolar disorder.</p> <p>A review of the PASRR Level I Screen, dated 03/14/24, and completed by the Assistant Director of Nursing (ADON) showed Resident #36 only had a mental illness of bipolar disorder and major depressive disorder and revealed no Level II was required. There was no indication that the resident had diagnoses of unspecified dementia with psychotic disturbance, mood disturbance, anxiety, and generalized anxiety disorder.</p> <p>On 05/22/24 at 4:15 p.m. the ADON confirmed she completed the PASRR Level I Screen. She stated she was not sure if dementia should have been reflected on the PASRR. She did not put a check mark in the box for anxiety disorder because the resident was not taking any medications for anxiety.</p> <p>The policies and procedures provided by the facility titled, Preadmission Screening and Resident Review (PASRR) revised on 11/08/21 revealed the following:</p> <p>Policy:</p> <p>The center will assure that all Serious Mentally Ill (SMI) and Intellectually Disabled (ID) residents receive appropriate pre-admission screenings according to Federal/State guidelines. The purpose is to ensure that the residents with SMI or are ID receive the care and services they need in the most appropriate setting.</p> <p>Procedure:</p> <p>1. It is the responsibility of the center to assess and assure that the appropriate preadmission screenings, either Level I or Level II, are conducted and results obtained prior to admission and placed in the appropriate section of the resident's medical record.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50570</p> <p>Based on interview, observation, and record review, the facility failed to develop and implement a person-centered care plan to meet the resident's communication needs for one (Resident #491) of one sampled resident and for one (Resident #87) of one resident sampled for Cardiopulmonary Resuscitation (CPR) status.</p> <p>Findings included:</p> <p>1. On [DATE] at 1:17 p.m. Resident #491 was observed in her room laying down in bed. Resident #491's [family member], the resident's responsible party, was speaking in Spanish with her roommate, Resident #491's [family member] stated the resident did not speak English and asked for the interview to be conducted in Spanish. Both Resident #491's [family member] and her roommate stated the roommate would help communicate with staff, in Spanish, in the [family member's] absence. Resident #491's [family member] stated the nurse on shift during the day spoke Spanish. At 1:24 p.m. Staff F, Registered Nurse (RN) entered the room and asked the resident, in Spanish, if she was having any headaches, pain or dizziness. Resident #491 replied in Spanish. Resident #491's [family member] brought to Staff F's attention that the incision cite on her head was leaking and had discharge which was observed on her pillow. Staff F stated in Spanish that she would change the pillow and notify the medical provider.</p> <p>Review of Resident #491's Admission Record revealed an admitted [DATE].</p> <p>Review of Resident #491's current plan revealed diagnoses to include: malignant neoplasm of frontal lobe, cognitive communication deficit, need for assistance with personal care, and encounter for surgical aftercare following surgery on the nervous system. Further review of Resident #491's current plan did not reveal a focus, goal or interventions related to communication.</p> <p>Review of Resident #491's electronic medical record under Review of Assessments, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment.</p> <p>Review of Resident #491's Psychosocial Evaluation, with an effective date of [DATE], revealed the resident's preferred language was Spanish. Question number five on the evaluation included, Do you need or want an interpreter to communicate with a doctor or health care staff, the response indicated was, yes. The evaluation further showed, under the category Cognitive/Behavioral, that the resident was oriented to person, place, time, and situation. For communication ability, the psychosocial evaluation showed the resident read, wrote, made self understood, and responded to others.</p> <p>On [DATE] at 9:12 a.m. an interview with Staff F, RN revealed she spoke Spanish and communicated with Resident #491 in Spanish. She stated she heard other staff were supposed to use a translator if they did not speak the language the resident spoke. She stated sometimes the resident's roommate helped translate in Spanish. She stated due to her craniotomy surgery, Resident #491's communication response was slower.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 10:42 a.m. an interview with Staff G, Certified Nursing Assistant (CNA) stated she asked Resident #491's roommate to help with translating. She stated she always relied on Resident #491's roommate. She stated some staff speak Spanish and she could use them if needed. Staff G stated if the roommate was not available, she would try writing down what she wanted to ask Resident #491 and see if she could respond that way. She stated she asked the resident questions and she would shake her head yes or no. Staff G stated, I find a way to communicate with her.</p> <p>An interview on [DATE] at 12:55 p.m. with the Director of Nursing (DON) revealed the nursing station has information for the translator service. She stated the expectation was for staff to use the translator service when a staff member did not speak the same language as the resident. The DON stated it was okay to use staff members to assist with translating, but she was reluctant to use another resident. The DON stated it was not okay to use another resident to assist with translating if they were communicating about medical information. The DON stated she preferred the staff used the translator services. She stated the staff did not have to use clinical staff members to translate. She stated any staff was okay to use to assist with translating. The DON stated it was okay to use [vendor name] translate on the phone if necessary.</p> <p>An interview with the Social Services Director on [DATE] at 3:57 p.m. revealed she knew Resident #491's primary language was Spanish and she was Cuban. The Social Services Director stated she used the translator services to speak with Resident #491. She stated the [family member] was present and helped translate as well. The Social Services Director was asked about Resident's #491's MDS assessment and Psychosocial Evaluation. She stated she knew the resident understood the questions asked from the assessment and evaluation because the [family member] was present and assisted with translating in addition to the translator services.</p> <p>A review of the facility's policy titled, Language Access Plan, with an effective date of [DATE] revealed in the procedure:</p> <p>4. Effective communication with LEP [limited English proficiency] individuals requires the Care Center to have language assistance services in place. The Care Center offers communication in the following forms:</p> <p>a. Oral communication: assistive service may come in the form of in-language communication (bilingual staff member communicating directly in an LEP person's language), or interpreting.</p> <p>b. Written communication: translation is the replacement of written text from one language to another; a translator must be qualified and trained in order to be recognized as appropriate.</p> <p>2. A review of the Admission Record showed Resident #87 was initially admitted to the facility on [DATE] with a primary diagnosis of respiratory failure.</p> <p>A review of the Order Listing Report with a date range of [DATE]-[DATE] showed an active Do Not Resuscitate (DNR) order.</p> <p>A review of the Care Plan with a last showed completed date of [DATE] showed no care plan was developed for Resident #87 related to code status.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 5:20 p.m., the Minimum Data Set (MDS) Coordinator stated a care plan should have been developed related to the code status for Resident #87 and she did not know why the care plan was not developed.</p> <p>The policy and procedures provided by the facility Plans of Care revised [DATE] showed the following:</p> <p>Policy:</p> <p>An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and update in accordance with state and federal requirements.</p> <p>39438</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438</p> <p>Based on record review and interviews, the facility failed to review and revise the care plan for one resident (#87) out of the sampled thirty-nine residents.</p> <p>Findings included:</p> <p>On 05/20/24 at 11:28 a.m. Resident #87's room door was observed with signage that showed enhanced barrier precautions.</p> <p>A review of the Admission Record revealed Resident #87 was initially admitted to the facility on [DATE] with diagnoses to include candidiasis and pneumonia.</p> <p>Section I - Active Diagnoses of the Minimum Data Set (MDS), dated [DATE], showed Resident #87 had an active diagnosis of pneumonia.</p> <p>The care plan with a focus area that showed Resident #87 had candida auris was initiated on 04/02/24. Interventions included but were not limited to contact isolation.</p> <p>The care plan with a focus area that showed Resident #87 was on antibiotic therapy related to sepsis and pneumonia was initiated on 04/23/24. Interventions included but were not limited to administer antibiotic medications as ordered by physician.</p> <p>A review of the Order Listing Report with an order date range of 03/01/24 to 05/31/24 revealed the following active orders:</p> <p>enhanced barrier precaution related to C. Auris,</p> <p>Fluconazole oral tablet 100 MG (milligram)- Give 1 tablet via gastrostomy tube (G-Tube) at bedtime for oral candidiasis for 13 days.</p> <p>There were no additional orders in place related to precautions or isolation and there were no orders in place for antibiotic therapy for sepsis and pneumonia.</p> <p>On 05/22/24 at 4:10 p.m. the Assistant Director of Nursing (ADON) stated if candida auris was active, the resident would be on contact precautions and if candida auris was colonized, then the resident would be on enhanced barrier precautions. All residents in the facility that had candida auris were colonized and were on enhanced barrier precautions. The ADON stated the care plan that indicated Resident #87 was on contact isolation for candida auris was developed when she was admitted to the facility. She was now colonized and on enhanced barrier precautions and had orders in place for enhanced barrier precautions. Resident #87 was no longer on antibiotics for pneumonia or sepsis, per the ADON.</p> <p>On 05/22/24 at 5:22 p.m. the MDS Coordinator stated the care plan should have been updated.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Aspire at Seminole		STREET ADDRESS, CITY, STATE, ZIP CODE 9393 Park Blvd Seminole, FL 33777	

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the policy and procedures provided by the facility titled, Plans of Care, revised 09/25/17, revealed the following:</p> <p>Policy:</p> <p>An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and update in accordance with state and federal requirements. Review, update, and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of OBRA MDS assessment, and as needed.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441</p> <p>Based on interview, observation, and record review, the facility failed to ensure the proper and timely interventions to prevent pressure ulcers for one (Resident #290) out of three sampled residents.</p> <p>Findings include:</p> <p>On 5/20/24 at 9:30 a.m., an interview was conducted with the family of Resident #290. Resident #290's family member stated the resident had a pressure sore on her bottom and left ankle, stating, we aren't too surprised because she has been in a regular bed since she has been here. Resident #290 was sitting in bed slightly less than ninety degrees upright while her family member attempted to assist with a high protein yogurt brought from the family member's home. The family member stated, I know a diet high in protein will help heal her wounds. Resident #290 had both her legs drawn in close to her buttocks and incapable of naturally straightening her legs.</p> <p>A review of Resident #290's Admission Record showed an admitted [DATE] with a primary diagnosis of urinary tract infection. Secondary diagnoses include but were not limited to metabolic encephalopathy, severe protein-calorie malnutrition, fall resulting in unspecified fracture of upper end of right humerus routine healing, congestive heart failure, generalized muscle weakness, dysphagia oropharyngeal phase, neuromuscular dysfunction of bladder, underweight, unspecified dementia and neuromuscular dysfunction of bladder.</p> <p>A review of Resident #290's Admission/Readmission Data Collection dated 5/03/2024 on page 12 lists skin (sacrum/ 23) with excoriation and on page 13(feet) Concerns for Feet marked as No. Further review of the Admission/Readmission Data Collection listed Resident #290 with an indwelling catheter secondary for a neurogenic bladder. On page 15, area number 5 for Heel Problems has the check box Mushy checked for bilateral heels.</p> <p>An observation was made on 5/22/24 at 2:00 p.m., of Resident #290's wound dressing changes. Staff D, Licensed Practical Nurse (LPN) and the Assistant Director of Nursing (ADON) were discussing the orders prior to assembling the materials needed for the dressing change. The Unit Manager was seen walking down the hallway to another treatment cart to retrieve [brand name] wound cleanser solution 0.125%. During the wound care, infection control and hand hygiene were observed. Resident #290 had a sacral open area of skin slightly right to the sacrum with minimal drainage. Exact measurements were not obtained but the length of the wound appeared to be palm size and the width appeared to be a thumb size wide and depth could not be determined. Resident #290 had an unsecured indwelling catheter leaving a deep groove in the resident's perineum/buttocks area. Resident #290's wound care continued to the left lateral malleolus area where a dime-sized open area was observed. Resident #290 was in a low air loss mattress and a soft boot was placed to left foot/ankle after wound care.</p> <p>A review of Resident #290's physician orders have the following orders:</p> <p>Low air loss mattress ordered on 5/20/24 with a start date of 5/21/24.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Treatment: Sacrum, cleanse with [brand name] wound cleanser solution 0.125%, pat dry, apply nickel thick [brand name] ointment and cover with foam dressing every day shift for wound care and as needed for soiled /dislodged dressing ,ordered 5/22/24 with a start date of 5/23/24.</p> <p>Treatment: Left lateral malleolus, cleanse with [brand name] wound cleanser solution 0.125%, pat dry, apply [brand name] wound cleanser moistened gauze to wound bed and cover with foam dressing as needed for wound care soiled/dislodged, ordered 5/22/24.</p> <p>Weekly skin sweeps ordered on 5/05/24.</p> <p>Wound consult ordered on 5/20/24.</p> <p>Health shake put amount ordered PO (oral) in additional direction two times a day related to unspecified severe protein-calorie malnutrition to assist with meeting estimated nutrition needs, this will provide an additional 220 Kcal, 6 grams of protein per 4 oz serving ordered on 5/08/24.</p> <p>A record review of Resident #290 s Braden Scale for Prediction Pressure Sore Risk-CHC dated 5/03/24 effective 16:41 (4:41 p.m.) scored the resident with 15 at Risk.</p> <p>A record review of Resident #290 s Braden Scale for Prediction Pressure Sore Risk-CHC dated 5/10/24 effective 05:11 (5:11 a.m.) scored the resident with 13 Moderate Risk.</p> <p>A record review of Resident #290 s Braden Scale for Prediction Pressure Sore Risk-CHC dated 5/17/24 effective 05:13 (5:13 a.m.) scored the resident with 12 High Risk.</p> <p>A review of weekly skin sweeps dated 5/10/24 listed #48 as left ankle (outer) and #53 sacrum as current skin conditions.</p> <p>A review of Nutrition Form with MNA-V2 page 1 number 4 dated 5/08/24 had skin integrity checked in the box for intact.</p> <p>A review of [wound care physician service] consult dated 5/17/24 stated in subject line, I was asked to see this patient for my opinion on how to manage the patient's wound. Wound #1 left lateral malleolus is stage 4 pressure injury with initial measurements 1.5 cm length 1.5 cm width and 0.4 cm depth and 100% slough. Wound #2 sacrum with measurements 5 cm length, 6 cm width and no measurable depth and 50 % slough and 50% eschar. Plan of care recommendations were placed for wound management for Wound #1, left lateral malleolus, and wound #2, sacrum. Additional order recommendations were provided consisting of implementing pressure relieving measures and offloading as tolerated and registered dietitian consultation to implement nutritional plan to optimize nutrition and float heels, signed by [wound care physician service] consult on 5/22/24 at 5:32 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #290 Minimal Data Set (MDS), dated [DATE] (Admission) for Category C-Cognitive Patterns has a Brief Interview for Mental Status of 2, which indicated severe cognitive impairment. Section GG-Functional Abilities and Goals had Resident #290 requiring substantial/maximal assistance with eating and oral hygiene and dependent for showering, incontinence care, lower and upper dressing, personal hygiene, roll side to side in bed, sit to lying position or lying to sitting position, transfers, and ambulation in wheelchair. Section M- Skin Conditions question C - clinical assessment has yes checked for the resident at risk for developing pressure ulcers/injuries and no checked for the resident have one or more unhealed pressure ulcers/injuries.</p> <p>A review of Resident #290's Care Plan dated 5/17/2024 has a Focus: Potential for pressure injury development related to impaired mobility, excoriation on coccyx on admission PU (pressure ulcer) on sacrum area UNS (unstageable) and PU stage 4 on left lateral leg ankle. Goal: the resident will have intact skin, free of redness, blisters or discoloration by/through review date. The resident's pressure injury on sacrum will show signs of healing and have minimal risk of infection by /through review date. The resident's pressure injury on left lateral leg will show signs of healing and have minimal risk of infection by/through review date. Interventions: Administer treatments as ordered and monitor for effectiveness. Educate the resident and resident representative as to the cause of skin breakdown. Follow facility policies and protocols for the prevention and treatment of skin breakdown. Inform the resident and resident representative of any new area of skin breakdown. Monitor nutritional status. Serve diet as ordered, monitor intake and record. Monitor document report as needed any changes in skin status. Obtain and monitor lab diagnostic work as ordered. Report results to MD and follow up as indicated. The resident requires low air low mattress on bed with bolsters. Treat pain as per orders prior to treating, turning etc to ensure the resident's comfort. Weekly treatment documentation to include measurements of each area of skin breakdowns with, length, depth, type of tissue and exudate.</p> <p>On 5/23/24 at 12:53 p.m., an interview was conducted with the Director of Nursing. (DON). Resident #290's electronic chart related to initial skin assessment upon admission and further skin assessments during resident's stay were reviewed. Resident #290's hospital transfer paperwork was reviewed. The DON stated, we need to do a better job related to skin assessment and stated education will start immediately. The DON agreed Resident #290 was a high risk for skin breakdown and stated, we could have started implementing prevention sooner.</p> <p>A review of the facility's policy and procedures titled, Admissions Assessment revised date of 8/22/2017, states, at the time of admission or readmission, the Nurse shall initiate the admission data collection form or its electronic equivalent. Pertinent information shall be collected by physical review, interview with resident and family and review of the resident's available medical records. The data collection form or its electronic equivalent will be completed within 24 hours. Initiate care plan.</p> <p>A review of the facility's policy and procedures titled, Skin Evaluation, revised 4/01/2017, states the following policy, A licensed Nurse will complete a total body evaluation on each resident weekly, and prior to a hospital or other facility transfer/ discharge, paying particular attention to any skin tears, bruises, stasis ulcers, rashes, pressure injury, lesions, abrasions, reddened areas and skin problems.</p> <p>Procedure:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> 1. A Licensed Nurse will complete a total body evaluation on each resident weekly and document the observation on the Skin Evaluation form. 2. The evaluating nurse must date & each review. 3. If a resident is assessed as having a skin problem, the evaluating nurse will initiate the appropriate form. For pressure areas complete the Pressure Injury Record. For all other skin conditions, complete the Non-Pressure Skin Condition Record. 4. A Licensed Nurse will complete a total body evaluation on each resident prior to a hospital or other facility transfer /discharge. 5. The Licensed Nurse will document the observations on the Skin evaluation form. 		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438</p> <p>Based on observation, record review, and interview, the facility failed to ensure one (Resident #87) out of the sampled seven residents, who was fed by enteral means, received appropriate treatment and services per physician orders.</p> <p>Findings included:</p> <p>On 05/22/24 at 10:23 a.m., Resident #87 was observed in bed sleeping. The enteral feeding pump was observed at 65 ml per hour and the total fed was 12,217 milliliters (ml).</p> <p>A review of the Admission Record revealed Resident #87 was initially admitted to the facility on [DATE] with diagnoses to include dysphagia and pneumonia.</p> <p>Section C- Cognitive Patterns of the Minimum Data Set (MDS) showed Resident #87 was rarely/never understood.</p> <p>Section I- Active Diagnoses of the MDS showed Resident #87 had a diagnosis of dysphagia, oropharyngeal phase.</p> <p>Section K- Swallowing/ Nutritional Status showed the resident had a nutritional approach of feeding tube.</p> <p>A review of the Order Listing Report with a date range of 03/01/24-05/31/24 revealed the following active orders:</p> <p>Enteral feed order every 6 hours for hydration flush every 6 hours with 200 ccs of water for a total volume of 800 ml/day and</p> <p>Enteral feed order two times a day Glucerna 1.5 @ 65 ml/ hour (hr) x 18 hours or until total volume infused is 1200 ml, up at 1900 and down at 1300.</p> <p>The Medication Administration Record (MAR) dated 05/01/24 to 05/31/24 showed the total volume for the Glucerna was not infused to 1200 ml per day on 05/01 to 05/22 per physician's order. The MAR also showed the resident did not receive the hydration flush for a total volume of 800 ml per day per the physician's order.</p> <p>A review of the Weights and Vitals Summary revealed the following for the month of May:</p> <p>05/20/24 170 pounds (lbs.) (Mechanical Lift)</p> <p>05/07/24 160 lbs. (Mechanical Lift)</p> <p>The resident had a 10 lbs. weight gain in 13 days.</p> <p>(continued on next page)</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The care plan with a focus area of tube feeding initiated on 04/02/24 showed interventions that included but were not limited to the resident needs total assistance with tube feeding and water flushes.</p> <p>On 05/22/24 at 1:12 p.m., Staff D, Licensed Practical Nurse (LPN) stated this morning she checked the resident and made sure she was ok and gave her medications. She turned the enteral feeding pump off to give her medications. Resident #87 received 65 ml per hour and the machine turned off at 1:00 p.m. She did not do anything with the enteral feeding pump but turned it off and made sure the placement was ok. Staff D reported she did not document anything related to how much the resident was fed. She stated, My boss never told me to document anything. She reported she was not trained on how to calibrate the machine and she did not know how to determine how much Glucerna the resident had by reading the enteral feeding pump machine. This writer and Staff D walked to Resident #87's room and the enteral feeding pump machine was set at 65 ml/hr and total fed was 12,388 ml (photographic evidence obtained). The Glucerna attached to the machine indicated it went up at 4:00 am and was at 550 ml. When asked how she knew if Resident #87 received the total volume for the day, she stated she did not know. Staff D, LPN, then stated she was getting ready to turn the machine off because it goes off at 1:00 p.m.</p> <p>On 05/22/24 at 1:36 p.m., an interview with Staff H, LPN/Unit Manager (UM) was conducted. She was shown a picture of the enteral feeding pump that read, total fed 12,388 ml. She stated staff were continuously hanging up the Glucerna and not clearing out the enteral feeding pump to start the process over. Staff H stated she did not know how to use the machine because she had only been employed at the facility for one month. She reported she did not bring this concern up to the Administrator or Director of Nursing (DON).</p> <p>A review of the Education In-Service Attendance Record dated 02/12/24 showed the training was related to gastrostomy tube (G-Tube) and documentation. Staff D, LPN, and Staff H, LPN/UM did not complete this training.</p> <p>On 5/22/24 at 1:20 p.m., an interview with the Regional Registered Dietitian (RD) was conducted. He looked at the resident's current orders for enteral nutrition. He was shown the picture of the enteral feeding pump that read, total fed 12,388 ml. He stated the current volume was equivalent to 8 days. He stated the staff was supposed to clear or reset the machine once the volume reached the amount that was indicated on the order. The current order was 65 ml per hour to reach 1,200 ml per day. The RD stated the staff should be documenting on the resident's MAR when they clear or reset the machine and what the volume was at that time.</p> <p>On 05/22/24 at 4:20 p.m., the Assistant Director of Nursing (ADON) reported she had conducted a training related to the enteral feeding pumps, but they had a lot of new staff that had been hired.</p> <p>On 05/22/24 at 5:34 p.m., the DON stated her expectations were that staff follow the order. If the order was for 1200 ml then the volume should not exceed or go below that number. She expected the staff to come to her or the ADON for assistance.</p> <p>The policies and procedures provided by the facility Medication-Administration Via Enteral Tube revised 03/06/19 revealed the following:</p> <p>Record the medication(s) on the resources MAR.</p> <p>(continued on next page)</p>		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Document on the Nurse's Notes any problems encountered and any measures taken.

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015</p> <p>Based on record review, interview, and review of the facility's policy Medication Management-Psychotropic Medications, the facility failed to ensure side effects monitoring was in place for one (Resident #8) out of five residents reviewed for unnecessary and psychotropic medication regimen review.</p> <p>Findings included:</p> <p>Review of the Admission Record revealed Resident #8 was initially admitted to the facility 05/15/23 with diagnoses that included but not limited to Schizoaffective Disorder, Bipolar type, Parkinson's Disease without dyskinesia, Major depressive disorder, recurrent and anxiety disorder, unspecified.</p> <p>A review of the Order Summary Report showed the following psychotropic medication ordered:</p> <ul style="list-style-type: none"> - A physician order dated 05/11/24 showed, Xtapaza ER Oral Capsule ER 12-hour abuse- deterrent 9 MG- Give 1 capsule by mouth two times a day for chronic pain. - A physician order dated 05/07/24 showed, Duloxetine HCl Oral capsule Delayed Release Particles 60 MG- Give 1 capsule by mouth for Major Depressive Disorder Mood. - A physician order dated 05/07/24 showed, Seroquel Oral Tablet 100 MG - Give 1 tablet by mouth related to schizoaffective disorder, bipolar type. - A physician order dated 05/06/24 showed, Oxycodone HCl Oral Tablet 10 MG- Give 1 tablet my mouth every 4 hours as needed for chronic severe pain 7-10 on pain scale. <p>Review of the Quarterly Minimum Data Set (MDS) dated [DATE] showed in Section C-Cognitive Patterns Resident #8 has a Brief Interview for Mental Status (BIMS) of 12 which indicated moderate cognitive impairment. In Section I-Active Diagnoses the diagnoses of Anxiety disorder, Depression and Schizophrenia was marked Yes. In Section N-Medications the medications of Antipsychotic, Antidepressant, Antianxiety and Opioid was marked Yes.</p> <p>A review of Resident #8's care plan revealed the following areas:</p> <ul style="list-style-type: none"> -Focus Resident uses antidepressants medication related to Depression and insomnia. The Goal was The Resident will be free from discomfort or adverse reaction related to antidepressant therapy through the next review. The Interventions included Administer Antidepressant medication as ordered by the physician. Monitor/document side effects and effectiveness Q-shift and Monitor/document/report PRN adverse reactions to Antidepressant therapy. <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Focus Resident is on antipsychotic therapy related to schizophrenia bipolar type. The Goal was The resident will be/remain free from antipsychotic drug related complications. The Interventions included but not limited to Administer Antipsychotic medications as ordered by the physician. Monitor behavioral symptoms and side effects.</p> <p>-Focus The Resident uses anti-anxiety medications related to anxiety disorder. The Goal was The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. The Interventions included Administer Anti-Anxiety medication as ordered by the physician. Monitor/document side effects and effectiveness Q-shift and Monitor/document/report PRN adverse reactions to Anti-Anxiety therapy.</p> <p>A review of the May 2024 Medication Administration Report (MAR) revealed Side effects: 1) Tardive dyskinesia 2) hypotension 3) Sedation/drowsiness 4) increased falls/dizziness 5) headaches 6) Insomnia 7) Weakness 8) Visual Disturbance 9) gastrointestinal disturbances 10) Other .every shift for monitoring put in corresponding code with a start date of 10/30/23 and was discontinued on 05/05/24. The MAR showed Resident #8 received side effects monitoring on 05/01/24 with blanks on the MAR from 05/02/24-05/05/24 when discontinued.</p> <p>During an interview on 05/22/24 at 3:03 p.m., the Director of Nursing (DON) stated Resident #8 went out to the hospital on 05/01/24 and returned to the facility on [DATE]. The DON stated Resident #8's side effects monitoring order was discontinued during hospitalization and was not initiated again upon return to the facility on [DATE]. The DON confirmed Resident #8 had no side effects monitoring for psychotropic medications since being readmitted to the facility on [DATE]. The DON stated the facility's policy was for any resident with a psychotropic medication regimen there should be side effects monitoring conducted.</p> <p>A review of the facility's policy Medication Management-Psychotropic Medications revised date 10/24/22 showed Procedure: 1. Residents receiving psychotropic medication should have specific condition documented indications in the medical record. 4. Monitor behavior and side effects every shift utilizing the Behavioral Monitoring Flow Record (BMFR) or electronic equivalent. 12. Monitor resident's response to medication, including the effectiveness of the medication and potential adverse consequences.</p>		

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 05/23/2024
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.			
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>48441</p> <p>Based on observation, interview, and record reviews, the facility failed to ensure the medication error rate was less than 5.00%. Twenty-six medication administration opportunities were observed and three errors were identified for three residents (Residents #79, #22 and #6) of six residents observed. These errors constituted a 11.54% medication error rate.</p> <p>Findings Include:</p> <p>On 5/22/24 at 9:29 a.m., an observation was conducted during medication administration with Staff C, Licensed Practical Nurse (LPN) for Resident #79. Staff C dispensed the following medication:</p> <ul style="list-style-type: none"> -Aspirin 81 milligrams (mg) chewable one tablet -Carvedilol 3.125 mg one tablet -Plavix 75 mg one tablet -Ezetimibe 10 mg one tablet one tablet -Sertraline 50 mg one tablet -Senna Plus one tablet <p>A review of the physician orders dated 9/12/2023 for Resident #79 showed Telmisartan 20 mg one tablet by mouth once daily related to hypertension</p> <p>On 5/22/24 at 3:30 p.m., an observation was conducted during medication administration with Staff D, LPN for Resident #22. Staff D cleared the feeding pump total infused to zero and then programmed thirty-five milliliters (ml) per hour of Jevity 1.2 to be infused via Resident #22's percutaneous endoscopic gastrostomy (PEG) tube. Staff D, LPN, stated there was not a physician order for total amount of Jevity to be infused but rather to start at 2:00 p.m. and to disconnect from resident at 10:00 a.m. Staff D acknowledged hanging the enteral tube feeding late.</p> <p>A review of physician orders dated 5/08/2024, showed an enteral feed order of Jevity 1.2 at thirty-five ml per hour for twenty hours (on 2 pm and off 10 am).</p> <p>On 5/23/24 at 11:30 a.m., an observation was conducted during medication administration of Staff E, LPN performing an accu check and insulin coverage for Resident #6.</p> <p>Resident #6 accu check results were 176 milligrams per deciliter (mg/dl) requiring two units of Novolog 100 units/ml subcutaneous. Staff E, LPN failed to prime the insulin needle prior to injection of insulin.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Per Novolog Flex pen manufacturer's PDF: For each injection: 1. Select a dose of 2 units 2. Take off the outer needle cap (save it) and inner needle cap (throw it away) 3. With the pen pointing up, tap the insulin to move the air bubbles to the top 4. Press the button all the way in and make sure insulin comes out of the needle Repeat up to two more times with the same needle if needed If insulin does not come out after three times, change the needle and try again If insulin still does not come out after changing the needle, the pen may be broken. [screen shot obtained]</p> <p>On 5/23/24 at 12:30 p.m., an interview was conducted with the Director of Nursing regarding medication administration observed during the survey. The DON was notified of the medication error rate of 11.54%.</p> <p>A review of the facility's policy titled, Administering medications, revised April 2019 states the policy statement, Medications are administered in a safe and timely manner, and as prescribed.</p> <p>.</p> <p>4. Medications are administered in accordance with prescriber's orders, including any required time frame.</p> <p>.</p> <p>6. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48441</p> <p>Based on observation, interview, and record review, the facility failed to provide proper infection control practices for two (Residents #51 and #22) out of six residents observed during medication administration.</p> <p>Findings include:</p> <p>On 5/22/24 at 8:40 a.m., an observation was made of Staff A, Licensed Practical Nurse (LPN) administering eye drops to Resident #51. During administration, the tip of the dropper was observed touching the resident's eyelids from one eye to the next eye. Resident # 51 was sitting at an angle of ninety degrees with head tilted down. Resident #51 struggled to open eyes wide unassisted and closed when the eye dropper touched his lids. Staff A continued to administer the eye drops under the same circumstances for the next eye. The eye dropper medication was covered with its cap and returned to the box labeled with the resident's name and then returned to the medication cart.</p> <p>On 5/22/24 at 3:30 p.m., an observation was made of Staff D, LPN during medication administration of physician orders for Resident #22 's enteral feedings. Staff D demonstrated the process for checking for proper placement of a Percutaneous Endoscopic Gastrostomy (PEG) tube. Staff D lifted the resident's gown and pulled down the top part of the resident incontinence brief to expose her abdomen and then placed her stethoscope on the resident's abdomen auscultating in four different areas of the abdomen. Staff D then exposed the PEG tube to attach the tubing for enteral feeding to the PEG tube. Resident #22 is on Enhanced Barrier Precautions due to her PEG tube. Staff D was not wearing a gown during contact with the resident's PEG tube.</p> <p>On 5/23/24 at 12:30 p.m., an interview was conducted with the Director of Nursing regarding the breach of Infection Control during medication administration. The DON stated we have a young and inexperienced nursing staff but is confident with the proper education these issues will be resolved.</p> <p>A review of the facility's policy titled, Enhanced Barrier Precautions, August 2022, has the following policy statement: enhanced barrier precautions (EBPs) are utilized to prevent the spread of multidrug resistant organisms (MDROs) to residents.</p> <ol style="list-style-type: none"> 1. Enhanced barrier precautions are used as an infection prevention and control intervention to reduce the spread of multi resistant organisms to residents 2. EBP's employ targeted gown and gloves used during high contact resident care activities when contact precautions do not otherwise apply <ol style="list-style-type: none"> a. Gloves and gowns are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Examples of high -contact resident care activities requiring the use of gown and gloves for EBPs include:</p> <ul style="list-style-type: none"> a. Dressing b. bathing /showering c. transferring d. providing hygiene e. changing linens f. changing briefs or assisting with toileting g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etcetera) and h. wound care (any skin opening requiring a dressing). <p>.</p> <p>5. EBPs are indicated when contact precautions do not otherwise apply for residents with wounds and or indwelling medical devices regardless of MDRO colonization.</p> <p>.</p> <p>9. Staff are trained prior to caring for residents on EBPs.</p>