STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105985	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Palm Bay	5405 Babcock St NE Palm Bay, FL 32905

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on interview, and record review, the facility failed to ensure physician's ordered discharge medications were timely provided for 1 of 3 residents reviewed for Admission, Transfer, and Discharge, of a total sample of 8 residents, (#7). Findings: Review of the medical record revealed resident #7, a [AGE] year old female was admitted to the facility from a Long Term Care Hospital on 8/17/24, and readmitted after re-hospitalization from an acute care hospital on 10/14/24. The resident's diagnoses included left-side paralysis, altered mental status, muscle weakness, unsteadiness on feet, cerebrovascular (brain vessel) disease, chronic atrial fibrillation (heart rhythm dysfunction), high blood pressure, anxiety disorder, anemia (low blood iron), presence of pacemaker, abnormal coagulation (blood clotting), major depressive disorder, insomnia, Urinary Tract Infection (UTI), Extended Spectrum Beta Lactamase (ESBL) (bacteria in urine) resistance, and resistance to multiple antimicrobial drugs (antibiotics). The most recent comprehensive Minimum Data Set Significant Change Assessment with an Assessment Reference Date (ARD) of 10/17/24 noted during the look back periods, resident #7 scored 15 out of 15 on the Brief Interview for Mental Status that indicated she was cognitively intact, and no behaviors or rejections of evaluation or care occurred. The assessment showed the resident required substantial/maximum staff assistance to complete Activities of Daily Living (ADL), was dependent for functional mobility, did not walk, was always incontinent of bladder and bowel functions, reported occasional 6 out of 10 (0-10 scale) pain, and received high-risk anti-depressant, anti-coagulant (blood thinner), opioid, and intravenous (IV) antibiotic medications. The MDS Discharge Assessment with an ARD of 12/23/24 showed resident #7 was discharged to Home/Community with Provision of Current Reconciled Medication List to Resident at Discharge provided by Verbal and Paper-based Route Transmission to Resident. Discharge Planning occurred for the resident to return to the community with an un-named Local Contact Agency (LCA) referral. The Care Plan Report focuses included: potential for fluid deficit related to acute infection, complications related to UTI, pain, altered cardiovascular (heart vessels), high blood pressure, and diuretic (fluid removing), anti-depressant, anti-anxiety, and anti-coagulant (blood thinner) medication use with interventions to monitor for complications. (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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration Record (MAR) showed physician's medication orders for resident #7 at discharge included: Diltiazem 120 Milligrams (MG) once daily for blood pressure, Duloxetine 60 MG once daily for depression, Lasix 20 MG once daily for pleural effusion (lung fluid), Magnesium 400 MG twice daily for low magnesium, Metoprolol 50 MG twice daily for blood pressure, Pantoprazole 40 MG once daily for acid reflux, Potassium Chloride 40 Milliequivalent's (mEq) once daily for low potassium, and Coumadin 2 MG once every evening for blood clot prevention. The Discharge Plan and Instructions completed by the Social Services Director noted resident #7 was discharged home with family via non-emergency medical transportation services, medical equipment, and follow up care provided by Home Health Care (HHC) services. The form read, . resident will be having a safe discharge, location: home with nephew. Resident has pharmacy, HHC and DME (Durable Medical Equipment) in place . Medication list provided upon discharge to the new provider . In a telephone interview, on 3/05/25 at 11:18 AM, resident #7's daughter recalled when her mother discharged home on 12/23/24, two days before the Christmas holiday, she didn't have all of her prescription medications on hand at home nor were they sent to her local pharmacy. She said she called the facility and was told they were not a pharmacy and they could not deliver any medications. She said she had to come to the facility and pick up the medications, but there were only one or two Coumadin pills. She explained she was very upset and worried, especially about the blood thinner because her mother previously had a stroke. On 3/04/25 at 2:24 PM, the Social Services Director explained that discharge planning started on admission and at that time, she collected information from the resident or family about who their community physician was, and what pharmacy they used so nurses would have it to ensure prescriptions were included for a safe discharge. She recalled when resident #7 discharged , the former Unit Manager was leaving and there was some missing items from nursing she had to complete. She said she did not have credentials to obtain physician's orders for medications and recalled on 12/24/24, Christmas Eve, the Director of Nursing (DON) had resident #7's daughter on the phone and she reported the resident was missing her prescription medications. The Social Services Director said she thought the Medical Director was called for assistance but there was an issue because the pharmacy was closed for the holiday and the resident's daughter had to come and pick up the left over medications. On 3/04/25 at 2:56 PM, the DON recalled on 12/24/24 after resident #7 was discharged , he received a call from her daughter who was upset the facility had not sent medications or prescriptions to the resident's pharmacy. The DON said it had been over 24 hours since the resident left, so he called the physician for permission to allow her to pick up the resident's unused supply from the facility. He said she was upset because there were only approximately two Coumadin pills left. The DON explained, he told the resident's daughter she also had the option of going to a walk-in clinic or asking their Primary Care Physician (PCP) for a refill to the pharmacy. Review of resident #7's HHC nurses notes dated 12/24/24 showed the resident was not provided prescriptions or medications when she discharged from the facility on 12/23/24, and no medications were in the home. On 3/05/25 at 10:50 AM, Registered Nurse (RN) D recalled on or about 12/25/24, resident #7's daughter came to the facility after the resident discharged to retrieve her facility supply of prescription medications. The nurse explained he gave her the medications after he confirmed by telephone with the DON it was okay. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/04/25 at 3:12 PM, in a telephone interview, the resident's community Registered Pharmacist (RPh) checked their records and said the facility's APRN called in resident #7's prescriptions on 12/26/25, three days after the resident discharged . On 3/05/25 at 1:30 PM, the DON said nurses were responsible to ensure discharge medications were provided. He conveyed it was important for the facility to ensure residents were provided with adequate prescription medications by either their left over supplies with an doctor's order, a written prescription, or sent/called to their pharmacy. The DON explained the timing of Christmas Eve and the resident's pharmacy closing made it more difficult to get the medications called in. Review of the facility's standards and guidelines titled Interdisciplinary Discharge Planning dated 11/30/14 noted Care Management was responsible for coordination and contact for necessary outside services.

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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** 46665 Based on observation, interview, and record review, the facility failed to ensure a laboratory specimen was obtained and submitted per physician's orders for 1 of 4 residents reviewed for Quality of Care, of a total sample of 8 residents, (#7). Findings: Review of the medical record revealed resident #7, a [AGE] year old female was admitted to the facility from a Long Term Care Hospital on 8/17/24, and readmitted after re-hospitalization from an acute care hospital on 10/14/24. The resident's diagnoses included left-side paralysis, altered mental status, muscle weakness, unsteadiness on feet, cerebrovascular (brain vessel) disease, chronic atrial fibrillation (heart rhythm dysfunction), high blood pressure, anxiety disorder, anemia (low blood iron), presence of pacemaker, abnormal coagulation (blood clotting), major depressive disorder, insomnia, Urinary Tract Infection (UTI), Extended Spectrum Beta Lactamase (ESBL) (bacteria in urine) resistance, and resistance to multiple antimicrobial drugs (antibiotics). The most recent comprehensive Minimum Data Set Significant Change Assessment with an Assessment Reference Date of 10/17/24 noted during the look back periods, resident #7 scored 15 out of 15 on the Brief Interview for Mental Status exam that indicated she was cognitively intact. The assessment indicated resident #7 had no behaviors and no rejections of evaluation or care occurred. The assessment showed the resident required substantial/maximum staff assistance to complete Activities of Daily Living (ADL), was dependent for functional mobility, did not walk, was always incontinent of bladder and bowel functions, reported occasional 6 out of 10 (0-10 scale) pain, and received high-risk anti-depressant, anti-coagulant (blood thinner), opioid, and intravenous (IV) antibiotic medications. The Order Summary Report showed a physician's orders for Vancomycin Pre-Dose blood tests from 10/23/24 to 10/29/24, Vancomycin IV 1250 Milligrams for infection every other day from 10/15/24 to 10/31/24, removal of the IV catheter on 11/06/24, and Urinalysis and Culture (bacteria identification) on 11/12/24 and 12/20/24. The Care Plan Report focuses included: potential for fluid deficit related to acute infection, and complications related to UTI with interventions to obtain and monitor lab and diagnostic work; report results to physician and follow up as indicated. On 3/05/24 at 3:00 PM, Licensed Practical Nurse (LPN) C checked resident #7's medical record and recalled that she took a verbal order from Advanced Practical Registered Nurse (APRN) D for a urinalysis and culture because the resident had altered mental status. The nurse explained she normally collected the specimen right away but could not remember if she had collected it. She said she normally passed on to the oncoming shift when she wasn't able to collect a specimen and stated, it's important to collect it and get it sent timely to treat any infection. The December 2024 Treatment Administration Record (TAR) noted a Urinalysis/Urine Culture for altered mental status was signed by LPN A on 12/21/24 at 12:17 PM. The TAR Schedule read, SENT Uncollected 12/20/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/06/25 at 11:15 AM, the Director of Nursing (DON) said LPN A was on leave and unavailable for an interview. On 3/05/24 at 1:50 PM, LPN B explained nurses entered urine lab orders into the computer, printed a requisition, collected the specimen, stored it in the refrigerator for the Phlebotomist to pick up and transport to the lab, and noted the same on the hand-written monthly log kept in the lab binder on the nursing unit. The nurse stated it was very important to pass on to the oncoming shift if a specimen wasn't collected. Review of resident #7's Urinalysis Lab Results Report of 12/23/24 showed no results. The laboratory provider report dated 12/23/24 had no results and read, scheduled: 12/21/24 7:00 AM. On 03/05/25 at 1:30 PM, The DON said APRN D no longer worked at the facility. Unsuccessful attempts were made to reach APRN D by telephone on 3/05/25 at 3:12 PM and 3/06/25 at 11:02 AM. In a telephone interview on 3/05/24, the Customer Service Representative of the laboratory provider checked their records and said notes showed on 12/23/24, the facility called about resident #7's urine results and was informed the Phlebotomist noted to their nurses there was no specimen in the refrigerator for pick-up. The representative explained the specimen was reported as uncollected to the facility. On 3/05/25 at 1:03 PM, the Unit Manager said she was in the supervisor role for about 2 weeks. She checked the laboratory specimen log binder and explained nurses noted on hand written forms that urine specimens had been collected and stored in the refrigerator for pick up by the Phlebotomist. She was unable to locate the December 2024 log. On 3/06/25 at 11:45 AM, the Unit Manager recalled on 3/05/24, she contacted the lab about resident #7's urine test ordered on 12/20/24. She said the lab indicated to her they never received the specimen and their Phlebotomist noted it was not in the unit's refrigerator. She provided specimen logs she was able to locate that were missing November and December 2024 records. On 3/06/25 at 11:20 AM, the DON said he wasn't sure what happened with resident #7's urine specimen and it was possible the nurse signed it off in error. The DON explained he expected nurses to timely collect urine specimens, store them in the unit refrigerator, report to oncoming nurses if they hadn't collected it, and notify the physician if there were issues or concerns about collections. The DON said they were unable to locate the December logs and the former Unit Manager was responsible for their safe storage. Review of the Lab Book kept at the nurses' station included orders and specimen processing instructions for nurses that noted hand-written logs were used to note the status and location of specimens for Phlebotomists to pick up and transport to the lab.