STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106000	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Evans	3735 Evans Ave Fort Myers, FL 33901

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure residents were free from abuse, including but not limited to physical restraint not required to treat the resident's medical symptoms for 1 (Resident #1) of 1 resident reviewed for physical restraint. The findings included: Facility policy titled Abuse, Neglect, Exploitation & Misappropriation Revision date 11/16/2022 indicated Abuse is the willful infliction of injury. Willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Review of the clinical record revealed Resident #1 was re-admitted to the facility on [DATE]. Diagnoses included unspecified dementia without behavioral disturbance. The admission Minimum Data Set (MDS) assessment noted the resident's cognition was severely impaired with a Brief Interview for Mental Status score of 00. On 6/12/25, record review of Resident #1's chart revealed a progress note dated 6/11/25 reading: When I came back to the unit from B wing, I heard the resident yelling in the dining room. I went in to see what was going on and I saw one CNA holding the resident head and chest and the other by her arm trying to keep her in the chair. She would try to kick the other cna. They were trying to put her socks on. I told them to leave her alone and I assisted her to get out of the chair. It was noted that she had a bruise on her chest and on her Right arm and hand. On 6/12/25 at 10:14 a.m., Resident #1 was observed lying in bed with red and purple bruising noted to her chest approximately 3 inch x 2 inch, bruising to the left forearm and hand, and bruising to the right forearm and hand. On 6/12/25 at 10:40 a.m., Staff C Unit Manager said on 6/11/25 she came on shift and a different nurse told her that Staff D Registered Nurse (RN) walked in and found Resident #1 was screaming and she found one aide holding her with her palm on her forehead and her palm on her chest. There were 2 aides in the room at the time, Staff C said she went and checked Resident #1 as soon as she was told. She said Resident #1 now has a bruise on her chest. She said Staff D was still there charting and she had her write an incident, informed the Administrator and called the Director of Nursing (DON). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106000	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Evans	3735 Evans Ave Fort Myers, FL 33901

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 0600 Level of Harm - Actual harm Residents Affected - Few	On 6/12/25 at 10:54 a.m., in a telephone interview Staff D (RN) said she went in and 2 Certified Nurse Assistants (CNA) were holding Resident#1 in the chair. One CNA had her by the head and the chest, and the other CNA was holding her hand at first and then her feet. Resident #1 started kicking at the CNA and she let go. Staff D said Resident #1 was agitated and screaming. Staff D said she told the CNA's to leave her alone and don't touch her. Staff D said she has had abuse training and she didn't like the way the CNA's were holding her. She said Resident #1 sustained bruises. Staff D said they are not allowed to restrain residents, and they were restraining her. Staff D said she guessed they were trying to keep her in the chair because she was trying to get up. I walked in and the one CNA backed off, I said what are you doing? On 6/12/25 at 10:57 a.m., in a telephone interview Staff E (CNA) said Resident #1 didn't want to sit and she helped her to sit down and the other CNA called the nurse. Staff E said, We did nothing wrong. Trying to get her to sit, she don't want to, she try to get up, I help for her to sit down. Staff E said she has had abuse and has never done nothing like that. Review of the facility's incident investigations revealed on 6/11/25 Staff F (CNA) said Resident #1 had been screaming in her bed, left her bed and entered the hallway. Staff F said Resident #1 was screaming and she tried to get her to sit down but she got up again and was screaming so she called the nurse to come see her. On 6/12/25 at 12:23 p.m., the DON said was out of the building at the time of the incident, but if they were truly holding her, it would be considered a restraint. DON said it was all still in the investigation phase and she didn ' t have all the facts, a lot of pieces still haven't been completed, but it would not be right to hold someone physically down in a chair. On 6/12/25 at 2:26 p.m., the Administrator said they are considering the incident as abuse. He said the investigation was still in progress and is an ongoing process at this time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106000	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Evans	3735 Evans Ave Fort Myers, FL 33901

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to permit residents to remain in the facility and allow residents to return to the facility following hospitalization for 2 (Residents #2 and #3) of 3 residents reviewed following hospitalization. The findings included: Facility policy titled Transfer/Discharge Notification & Right to Appeal, last revised 4/28/25 indicated: Policy: Transfer and discharges of residents, initiated by the center (facility initiated) will be conducted according to Federal and/or State regulatory requirements. Procedure: Emergency transfers to Acute Care: Residents who are sent emergently to an acute care setting, must be permitted to return to the center. If the center initiates a discharge while the resident is in the hospital, the center must show evidence that the resident's status at the time of the return to the center meets the criteria listed above (A-D). a. The transfer or discharge is necessary for the resident's welfare and the residents needs cannot be met in the center. b. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the center. c. The safety of individuals in the center is endangered due to clinical or behavioral status of the resident. d. The health of individuals in the center would otherwise be endangered. Review of the facility assessment tool updated 2/6/25 indicated the facility cared for residents which included psychiatric/mood disorders, heart/circulatory conditions, neurological conditions and respiratory conditions. The facility assessment further indicated it treated special treatments and conditions including tracheostomy care and behavioral health needs. Review of the discharge list provided by the facility on 6/12/25 indicated Resident #2 had been discharged /transferred to another hospital on [DATE]. Resident #3 was not found on the discharge list, but review of his Electronic Health Record indicated he had been discharged on 2/20/25. 1. On 6/12/25 a record review of Resident #2's chart revealed no progress notes indicating why she had been sent out on 11/8/24 or where she went following discharge/transfer. On 6/12/25 at 12:40 p.m., the Director of Nursing (DON) said Resident #2 went out to the hospital in November, then she went to a Long Term Acute Care hospital (LTAC). DON said Resident #2 wasn't ready to return until sometime at the end of December or January, but the facility didn't have any beds at that time. DON said she did not know where Resident #2 went from the LTAC. DON said when a resident was sent out they should go with a face sheet, med orders, Advanced Directives, bed hold and transfer/discharge/ombudsman notice. DON said she could not provide bed hold or transfer and discharge notice for Resident #2 as they were having a problem with that at the time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106000	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Evans	3735 Evans Ave Fort Myers, FL 33901

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 3:46 p.m., the DON provided a SBAR communication form (Situation, Background, Assessment, Recommendation: is a communication tool to share medical information and factors contributing to current situation clearly and concisely) which indicated fall. The DON explained Resident #2 did not actually have a fall but had been lowered to the floor with a hoyer lift as staff thought she was having a seizure. DON said Resident #2 would not let them pick her back up, so the firemen came and picked her back up. She was having muscle spasticity and shaking. DON said Resident #2 refused to go to the hospital and they placed her in a Broda chair. DON said later, Resident #2 complained about pain and was sent out to the hospital. DON said the SBAR was the only documentation of what occurred that caused Resident #2 to be sent out to the acute care hospital. On 6/12/25 at 1:49 p.m., the Admissions Coordinator said she believed Resident #2 had gone to another Skilled Nursing Facility in the area. She said she honestly could not tell me why the facility didn't take Resident #2 back in December/January, but it had been a Corporate decision and she had not made the decision herself. She said she was unable to pull up the dialogue between herself and the hospital as it was too long ago. On 6/12/25 at 2:28 p.m., the Administrator said he could not say for sure why the facility did not take Resident #2 back, did not know if it was bed availability and could not say for sure why they did not take her back. He said he did not know why she had been sent out, but it had something to do with medical, because they sent her to the hospital. He said he believed she had been at the hospital for a while, and they probably filled her bed. He said he was not aware a bed hold or transfer/discharge notice had not been completed. On 6/12/25 3:08 p.m., the Administrator said Resident #2 went to a LTAC. He said they had filled her bed, and was unsure if they had any other beds available. Administrator was asked for a census for the day Resident #2 was to return and he said he didn't know what date that was. On 6/12/25 at 4:20 p.m., the Administrator said he was unable to find out any further information about what day she was able to come back to skilled nursing, but he did find out it was something to do with her trach. He agreed Resident #2 had been at the facility for years and the trach was not something new for her. He said it had become more complicated and the nurses there wouldn't be able to deal with it, but could not say what that was. 2. On 6/12/25 a record review of Resident #3's chart revealed he had been discharged on 2/20/25. A progress note dated 2/20/25 indicated around 6 p.m. Resident #3 complained of chest pain, had been given nitroglycerin, pain continued and he was sent out to the hospital. A further progress noted dated 2/11/25 indicated the nurse had called the hospital, would remain in their care, cardiology would examine and determine next action. There was no further documentation in Resident #3's chart indicating what had happened with Resident #3. On 6/12/25 at 12:40 p.m., the DON said Resident #3 had been sent to the hospital, and then discharged to a facility on the East Coast be closer to his girlfriend. The DON said the facility would have taken him back. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106000	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Evans	3735 Evans Ave Fort Myers, FL 33901

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 1:49 p.m., the Admissions Coordinator said the facility had been trying to put restrictions on Resident #3 from smoking in front of the building, and then Resident #3 chose to go to a facility on the East Coast. When the dialogue between the hospital and facility was reviewed, it revealed the facility had told the hospital they were unable to accept patient, care needs exceed current capacity, patient is a danger to himself and others. (photo obtained) On 6/12/25 at 2:00 p.m., the Regional Nurse said there was no bed hold documentation for Resident #3. On 6/12/25 at 3:46 p.m., the DON said Resident #3 was never [NAME] acted. DON said she didn't necessarily know that he was a threat to himself or others, he just didn't like following rules while he was here, complained about everything and pushed the rules, like not supposed to smoke at this time, he would smoke, if dining room not open he would go in there, he just liked to be confrontational. DON said he was not involved in any physical altercations, he was just all talk. She said as far as she could see in his chart, he was never [NAME] Acted since admission on [DATE]. On 6/12/25 at 2:28 p.m., the Administrator was asked why Resident #3 didn't return to the facility. He said it was probably in the chart and said Resident #3 was a heavy smoker, refused to give them his lighter, and was non-compliant. Administrator said he didn't recall if he was given a notice of discharge. Administrator said the decision to take someone back or not is a team decision that includes himself, the DON, Social Services, Business Office and maybe even the regional team was involved. On 6/12/25 at 3:08 p.m., the Administrator said no 30 day notice of discharge had been issued to Resident #3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106000	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Evans	3735 Evans Ave Fort Myers, FL 33901

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure required documentation was completed in the event of transfer or discharge for 3 (Resident #2, #3 and #6) of 3 residents reviewed for transfer and discharge. The findings included: Facility policy titled Transfer/Discharge Notification & Right to Appeal, last revised 4/28/25 indicated: Policy: Transfer and discharges of residents, initiated by the center (facility initiated) will be conducted according to Federal and/or State regulatory requirements. Procedure: Emergency transfers to Acute Care: Residents who are sent emergently to an acute care setting, must be permitted to return to the center. If the center initiates a discharge while the resident is in the hospital, the center must show evidence that the resident's status at the time of the return to the center meets the criteria listed above (A-D). a. The transfer or discharge is necessary for the resident's welfare and the residents needs cannot be met in the center. b. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the center. c. The safety of individuals in the center is endangered due to clinical or behavioral status of the resident. d. The health of individuals in the center would otherwise be endangered. Facility policy further indicated: Documentation: When the center transfers or discharges a resident under any of the circumstances listed above the facility will ensure that the transfer or discharge is documented in the resident's medical record. Notice Before Transfer: Center must notify the resident and resident representative of the transfer or discharge and the reason for the move in writing. Review of the discharge list provided by the facility on 6/12/25 indicated Resident #2 had been discharged /transferred to another hospital on [DATE]. Resident #6 had been discharged /transferred to another hospital on 5/29/25. Resident #3 was not found on the discharge list, but review of his Electronic Health Record indicated he had been discharged on 2/20/25. 1. On 6/12/25 a record review of Resident #2's chart revealed no progress notes indicating why she had been sent out on 11/8/24 or where she went following discharge/transfer. On 6/12/25 at 12:40 p.m., the Director of Nursing (DON) said Resident #2 went out to the hospital in November, then she went to a Long Term Acute Care hospital (LTAC). DON said Resident #2 wasn't ready to return until sometime at the end of December or January, but the facility didn't have any beds at that time. DON said she did not know where Resident #2 went from the LTAC. DON said when a resident was sent out they should go with a face sheet, med orders, Advanced Directives, bed hold and transfer/discharge/ombudsman notice. DON said she could not provide bed hold or transfer and discharge notice for Resident #2 as they were having a problem with that at the time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106000	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Evans	3735 Evans Ave Fort Myers, FL 33901

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/25 at 3:46 p.m., the DON provided a SBAR communication form (Situation, Background, Assessment, Recommendation: is a communication tool to share medical information and factors contributing to current situation clearly and concisely) which indicated fall. The DON explained Resident #2 did not actually have a fall but had been lowered to the floor with a hoyer lift as staff thought she was having a seizure. DON said Resident #2 would not let them pick her back up, so the firemen came and picked her back up. She was having muscle spasticity and shaking. DON said Resident #2 refused to go to the hospital and they placed her in a Broda chair. DON said later, Resident #2 complained about pain and was sent out to the hospital. DON said the SBAR was the only documentation of what occurred that caused Resident #2 to be sent out. On 6/12/25 at 1:49 p.m., the Admissions Coordinator said she believed Resident #2 had gone to another Skilled Nursing Facility in the area. She said she honestly could not tell me why the facility didn't take Resident #2 back in December/January, but it had been a Corporate decision and she had not made the decision herself. She said she was unable to pull up the dialogue between herself and the hospital as it was too long ago. On 6/12/25 at 2:28 p.m., the Administrator said he could not say for sure why the facility did not take Resident #2 back, did not know if it was bed availability and could not say for sure why they did not take her back. He said he did not know why she had been sent out, but it had something to do with medical, because they sent her to the hospital. He said he believed she had been at the hospital for a while, and they probably filled her bed. He said he was not aware a bed hold or transfer/discharge notice had not been completed. On 6/12/25 3:08 p.m., the Administrator said Resident #2 went to a LTAC. He said they had filled her bed, and was unsure if they had any other beds available. Administrator was asked for a census for the day Resident #2 was to return and he said he didn't know what date that was. The Administrator said no 30 day notice of discharge had been issued to Resident #2. On 6/12/25 at 4:20 p.m., the Administrator said he was unable to find out any further about what day she was able to come back to skilled nursing, but he did find out it was something to do with her trach. He agreed Resident #2 had been at the facility for years and the trach was not something new for her. He said it had become more complicated and the nurses there wouldn't be able to deal with it, but could not say what that was. 2. On 6/12/25 a record review of Resident #3's chart revealed he had been discharged on 2/20/25. A progress note dated 2/20/25 indicated around 6 p.m. Resident #3 complained of chest pain, had been given nitroglycerin, pain continued and he was sent out to the hospital. A further progress noted dated 2/11/25 indicated the nurse had called the hospital, would remain in their care, cardiology would examine and determine next action. There was no further documentation in Resident #3's chart indicating what had happened with Resident #3. On 6/12/25 at 12:40 p.m., the DON said Resident #3 had been sent to the hospital, and then discharged to a facility on the East Coast be closer to his girlfriend. The DON said the facility would have taken him back. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106000	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Evans	3735 Evans Ave Fort Myers, FL 33901

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/25 at 1:49 p.m., the Admissions Coordinator said the facility had been trying to put restrictions on Resident #3 from smoking in front of the building, and then Resident #3 chose to go to a facility on the East Coast. When the dialogue between the hospital and facility was reviewed, it revealed the facility had told the hospital they were unable to accept patient, care needs exceed current capacity, patient is a danger to himself and others. (photo obtained) On 6/12/25 at 3:46 p.m., the DON said Resident #3 was never [NAME] acted. DON said she didn't necessarily know that he was a threat to himself or others, he just didn't like following rules while he was here, complained about everything and pushed the rules, like not supposed to smoke at this time, he would smoke, if dining room not open he would go in there, he just liked to be confrontational. DON said he was not involved in any physical altercations, he was just all talk. She said as far as she could see in his chart, he was never [NAME] Acted since admission on [DATE]. On 6/12/25 at 2:28 p.m., the Administrator was asked why Resident #3 didn't return to the facility. He said it was probably in the chart and said Resident #3 was a heavy smoker, refused to give them his lighter, and was non-compliant. Administrator said he didn't recall if he was given a notice of discharge. Administrator said the decision to take someone back or not is a team decision that includes himself, the DON, Social Services, Business Office and maybe even the regional team was involved. On 6/12/25 at 3:08 p.m., the Administrator said no 30 day notice of discharge had been issued to Resident #3. 3. On 6/12/25 a record review of Resident #6's chart revealed he had been discharged on 5/29/25. Progress note dated 5/29/25 indicated his gastrointestinal bag was leaking and there were two openings on his stomach. Resident #6 was sent to the hospital. There was no further documentation in Resident #6's chart indicating what had happened with Resident #6. No documentation of a bed hold was found in the chart. On 6/12/25 at 1:49 p.m., the Admissions Coordinator said the facility had been willing to accept the patient back however he chose to go to a different facility. This was verified on on review of the dialogue between the hospital and facility. On 6/12/25 at 2 p.m.,tThe Regional Nurse said there was no bed hold documentation found for Resident #2, #3 or #6.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106000	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Evans	3735 Evans Ave Fort Myers, FL 33901

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, records review and interviews, the facility failed to carry out activities of daily living (ADLs) including nail care and showers for 2 dependent residents, 12 and #16, of 5 residents reviewed for ADLs. The findings included: Review of facility policy titled Bathing / Showering revised 9/1/2017 which stated, Assistance with showring and bathing will be provided at least twice a week and PRN (as needed) to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and PRN cleansing. The resident's frequency and preferences for bathing will be reviewed at least quarterly during care conference. Review of clinical records for Resident #12 documented admission to the facility on 3/6/25. The most recent Brief Interview for Mental Status (BIMs) score on 5/9/25 was 0 indicating severe cognitive impairment. Shower / bath days are Mondays and Thursdays. Review for shower bed bath documentation showed only 4 bed baths provided between 5/1/25 and 6/12/25. Most recent bed bath was documented on 6/2/25. Review of clinical records for Resident #16 documented admission to the facility on 4/19/25. Shower / bath days are Mondays and Thursdays, and resident is care planned as dependent with one or 2 staff to assist with tub/ shower transfer. Documented in the clinical record shows Resident #16 prefers showers. Review of shower or bed bath documentation showed only 2 showers were provided between 5/1/25 and 6/12/25 otherwise bed baths were given despite documented preference. On 6/12/25 at 11:30 a.m., Resident #12 was observed in bed dressed in a hospital gown. The resident's hair was disheveled and appeared greasy. The resident's fingernails on her left hand were approximately an inch long, the fingernails on the resident's right hand were slightly shorter. Fingernails on both hands were observed to have dark brown debris under the nails and dark brown crusty debris around the cuticles of the fingernails. The resident was confused and unable to answer questions. On 6/12/25 at 11:50 a.m., during an interview Certified Nursing Assistant (CNA) Staff G said she had cleaned up Resident #12 that shift but had not given her a bed bath. CNA Staff G said when asked about Resident #12 fingernails, No they are not acceptable. They are too long and dirty. CNA Staff G said she did not know the routine for providing nail care for the residents. On 6/12/25 at 12:05 p.m., Licensed Practical Nurse (LPN) Staff H confirmed Resident #12's fingernails were too long and dirty. LPN was asked what was under her nails and replied, I don't know dirt or poop. We will clean her up. On 6/12/25 at 12:15 p.m., LPN Staff I, assigned to care for Resident #12 for the shift, looked at the resident's nails and said, Yes, they are very dirty, the left-hand nails are longer than the other hand. Asked what the process was for cleaning and trimming nails. LP, Staff I, replied, We have a binder to let podiatry know when to cut the nails. Confirmed she has not cut the residents assigned to her nails. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106000	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Evans	3735 Evans Ave Fort Myers, FL 33901

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 12:30 p.m., Unit Manager LPN Staff C said staff should be looking at the residents daily head to toe. Confirmed nurses may cut fingernails and the CNAs can clean and file nails. If the residents are diabetic, then we have podiatry do the toenails. Unit Manager LPN Staff C observed Resident #12 fingernails and said, They are filthy. They need to be cleaned out and trimmed. The Unit manager said nail care is to be done with the shower or bath twice a week and as needed. On 6/12/25 at 12:45 p.m., Resident #16 was observed in bed with disheveled greasy hair and long dirty nails. Debris noted under the nails of both hands. LPN Staff I viewed Resident #16 nails and said, Yes, they are also too long and dirty. They should have been trimmed. Sometimes the resident will eat with her hands that might be what is under the nails. On 6/12/25 at 12:55 p.m., Unit Manager LPN Staff C observed Resident #16 and said, Yes, her hair is dirty, and her nails are too long with dirt under them. We will get her cleaned up. On 6/12/25 at 1:30 p.m., during an interview the Director of Nursing (DON) confirmed residents' nails should be clean and trimmed saying nail care is provided on shower or bath day. The DON confirmed the process is that nurses can trim nails and CNAs can file them. The DON reviewed the clinical records for Resident #12 and Resident #16 and confirmed there are no refusals documented for either resident related to showers or nail care. On 6/12/25 at 2:40 p.m., the facility Administrator said, I expect the CNAs to clean and trim nails and provide showers as scheduled. It's part of their job.