

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2025
NAME OF PROVIDER OR SUPPLIER Aspire at Evans		STREET ADDRESS, CITY, STATE, ZIP CODE 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. (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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy and procedures, staff and resident interviews, the facility failed to protect the resident's right to be free from physical, and verbal abuse for 1(Resident #999) of 3 residents reviewed for abuse.The findings included: Review of the facility policy N-1265 Abuse, Neglect, Exploitation and Misappropriation effective 11/30/14 (revised 11/16/22) documented It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse . Employees of the center are charged with a continuing obligation to treat residents so they are free from abuse . No employee may at any time commit an act of physical, psychological, or emotional abuse . against any resident . Acts of abuse directed against residents are absolutely prohibited. Any action that may cause or causes actual physical, psychological or emotional harm which is not caused by simple negligence, constitutes abuse . All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights. Review of the clinical record revealed Resident #999 was a [AGE] year-old, Spanish speaking female with an admission date of 5/10/25. Diagnoses included displaced fracture of fifth cervical (neck) vertebra, peg tube (a tube inserted into the stomach to provide nutrition and hydration) placement, type 2 diabetes mellitus, hypothyroidism, and pain. Review of the Medicare 5 day Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 6/22/25 documented Resident #999 was dependent to go from sitting to standing and for transfers. The MDS noted Resident #999 scored 06 on the Brief Interview for Mental Status, indicating the resident's cognitive skills for daily decision making were severely impaired.On 7/7/25 at 9:09 a.m., Resident #999 was interviewed with the assistance of Registered Nurse (RN) Staff E translating in Spanish. The resident said a male therapist came to her room and yelled at her because she had pain in her back. He was very angry for no reason. She said he pulled her from the wheelchair (w/c) and forcibly put her into bed. She did not know why he did not take her to the therapy room. She does not speak English, did not understand him and did not offer her a translator. The resident said the therapist was fine when he came in but got angry with her, because she did not understand the instructions he gave her. When he put her in bed, she hurt her cervical area, she had a fracture there and had recently had surgery. She said she told the therapist he had hurt her, he smiled at her. Resident #999 said the therapist used a gait belt to lift her up out of the wheelchair and he threw her into bed. The resident said there was no other person in the room when the male therapist was providing care. She said she was yelling and crying. A female therapist and the nurse came into her room when they heard her yelling.She said when she started to yell and cry, the therapist left her room; he was very angry. He did not say anything to me. He told her about the therapy, and she did not understand him.Resident #999 said after it happened, she was anxious and fearful, she did not expect that to happen to her. She was screaming and crying because he had hurt her.Review of the facility's incident investigations revealed on 6/13/25 the facility initiated a physical and verbal abuse investigation for Resident #999.Review of the investigation revealed:On 6/13/25 at 3:30 p.m., Physical Therapy Assistant (PTA) Staff A and Occupational Therapist (OT) Staff D were assisting Resident #999 to transfer from her bed to the wheelchair. During the transfer PTA Staff A grabbed the resident's arms and started to yell at her and shake her for not following his directions for the transfer.Registered Nurse (RN) Staff C in her statement said on 6/13/25 at approximately 3:25 p.m., she was one room down the hallway and heard Resident #999 screaming out. She went to the resident's room and saw a male therapist with his hands on both of the resident's arms yelling and shaking her and he stated very loudly I told you not to do this. This is why you keep getting hurt. The resident was crying and stated that he hurt her and was pointing to her peg tube area.RN Staff C had a certified nursing assistant stay with the resident while she went to report the abuse.PTA Staff A said in his written statement that around 3:00 p.m., when he arrived in Resident #999's room, the resident was upset and started to complain in rapid Spanish which he didn't understand. The PTA gave her detailed instructions on how to transfer from the bed to the wheelchair and how to place her hands. After detailed instructions, the resident grabbed the wrong armrest and started to twist her arm and gave out a loud scream. PTA Staff A asked why, in a loud voice, she grabbed the wrong armrest despite all instructions given. That's when RN Staff C came into the room and witnessed the PTA's question to the resident and said, This is patient abuse.OT Staff D in her statement said she was in the room assisting PTA Staff A with Resident #999's transfer. The resident was positioned properly and educated numerous times by</p>		