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	02/26/2026

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interview the facility failed to ensure 3 (Residents #1, #4 and #6) of 4 residents reviewed with Baseline Care Plans, had those Care Plans developed and completed appropriately to include instructions needed to provide effective and person-centered care within 48 hours of the residents being admitted to the facility. The findings included: The facility's Plan of Care Policy and Procedures N-1015 dated 11/30/14, with a revision date of 9/25/17, stated the facility would develop and implement an Individualized Person-Centered Baseline Plan of Care within 48 hours of admission that included, but not limited to, initial goals based on the admission Orders, Physician Orders, Dietary Orders, Therapy Services, Social Services if applicable, and other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs were met appropriately until the Comprehensive Plan of Care was completed. 1. On 2/25/26 a review of Resident #1's medical record revealed he was admitted to the facility on [DATE] for rehabilitation services after a fall at home. Review of Resident #1's Baseline Care Plan revealed it was blank except for Resident #1's wife signature on page 4. The Baseline Care Plan did not contain the initial goals and instructions to provide effective care, to ensure Resident #1's needs were met prior to the completion of the comprehensive plan of care. The baseline care plan did not address his history of falls or identify goals and interventions to prevent further falls.2. On 2/26/26 a review of Resident #4's medical record revealed he was admitted to the facility on [DATE] from the hospital with a discharge diagnosis of chest pain and transferred to a skilled nursing facility for rehabilitation services. Review of Resident #4's Baseline Plan of Care, dated 1/26/26, revealed page 1 was not completed, and the goal for falls/safety was circled but the interventions for that goal were not identified required. 3. On 2/26/26 a review of Resident #6's medical record revealed she was admitted to the facility 2/06/26 from the hospital with a discharge diagnosis of acute respiratory failures with hypoxia and was transferred to a skilled nursing facility for rehabilitation services. Review of Resident #4's Baseline Plan of Care dated 2/06/26 revealed page 1 was not completed, and the goals for falls/safety, oral/dental, pain, and anticoagulant use were circled but the interventions for those goals were not identified as required. On 2/26/26 at 11:01 a.m. in an interview with Staff A Unit Manager, she said when a resident was admitted to the facility, the admitting nurse was required to complete a Comprehensive Assessment to include a personalized Baseline Care Plan at that time. The next day she would review all resident(s) admitted the day prior to ensure the residents' Physician Orders were completed and in the computer, the admission Assessment was completed, and the Baseline Care Plan was completed to include the goals and personalized interventions for each goal as required. Staff A reviewed Residents #1, #4 and #6's admission Baseline Care Plan and confirmed their Baseline Care Plans were not completed appropriately with goals and interventions to ensure each goal was addressed as required. On 2/26/26 at 1:10 p.m. in an interview with the Director (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Of Nursing, she confirmed the facility's Plan of Care Policy stated the facility would develop and implement an Individualized Person-Centered Baseline Plan of Care within 48 hours of admission that included, but not limited to, initial goals based on the admission Orders, Physician Orders, Dietary Orders, Therapy Services, Social Services if applicable, and other areas needed to provide effective care of the resident that met professional standards of care to ensure that the resident's needs were met appropriately until the Comprehensive Plan of Care was completed. The DON said after she reviewed Residents #1, #4, and #6's Baseline Care Plan, she confirmed they were incomplete and did not identify the required goals and their interventions to ensure each resident needs were appropriately met until the Comprehensive Plan of Care was completed for that resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and resident medial record review, the facility failed to ensure 1 (Resident #1) of 4 residents reviewed with admission orders for an occupational, physical, and speech therapy evaluation and treatment as indicated had the assessments/services provided as ordered by the physician to evaluate the need for therapy and to treat as indicated by the assessment. The findings included:On 2/25/26 a review of Resident #1's medical record revealed the Medical Certification for Medicaid Long-Term Care and Services and Patient Transfer Form dated 1/14/26 stated Resident #1's primary diagnosis at the time of discharge from the hospital was a closed head injury and he was being discharged to a skilled facility for rehabilitation. Resident #1 was transferred to the skilled nursing facility on 1/15/26 with Physician Orders dated 1/16/26, for occupational therapy, physical therapy, and speech therapy evaluations and to treat as indicated. On 2/25/26 at around 11:30 a.m. in a phone interview with Resident #1's daughter, she said her father was admitted to the hospital after falling at home and was discharged to the skilled nursing facility to receive rehabilitation therapy prior to going home but was informed by Resident #1 and her mother, the rehabilitation therapy would not be started until 2/02/26. On 2/25/26 at 12:35 p.m. in an interview with the Director of Therapy, she confirmed Resident #1 was admitted to the facility on [DATE] with physician orders dated 1/16/26 for occupational therapy, physical therapy, and speech therapy evaluations and to treat as indicated. She said when a resident was admitted to the facility with orders for a therapy evaluation and treatment, the therapy department would normally complete the ordered evaluation within 48 hours. She said they had conducted a wheelchair evaluation for Resident #1 on 1/16/26 and provided him with a wheelchair on 1/16/26. She said they did not conduct a therapy evaluation for physical, occupational, and speech therapy as ordered on 1/16/26 but had scheduled those evaluations to be completed on 2/02/26. She said she had spoken to Resident #1 and his wife after his admission to the facility, and they agreed to conduct Resident #1 physical, occupational, and speech therapy evaluations on 2/02/26. She said the physical, occupational and speech therapy evaluations were not completed on 2/02/26 because Resident #1 was sent to the hospital on 2/02/26 for a change in mental status. She confirmed the therapy evaluations were not conducted as ordered on 1/16/26.On 2/25/26 at 1:35 p.m. in an interview with the Director of Nursing (DON), she confirmed Resident #1 was admitted to the facility on [DATE] after having a fall at home in December 2025. She confirmed Resident #1 had physician orders dated 1/16/26 to include occupational therapy, physical therapy, and speech therapy evaluations and to treat as indicated which were acknowledged by Resident #1's primary care physician on 1/21/26. She confirmed Resident #1's Physician Orders for occupational therapy, physical therapy, and speech therapy evaluations were not completed as ordered by the physician.