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	08/21/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, record review and staff interviews, the facility failed to ensure staff provided care and services with respect and dignity to 2 (Residents #69 and #23) of 21 cognitively impaired residents observed on the memory care unit. The findings included: 1. Review of the clinical record revealed Resident #69 was readmitted to the facility from an acute care hospital on 8/12/24. Diagnoses included fracture and surgical repair of the right wrist, vascular dementia, anxiety disorder, Alzheimer's disease, restlessness and agitation. The hospital discharge orders dated 8/12/24 included Xeroform (non-adherent dressing), dry dressing and volar (immobilizes and allows room for swelling) splint to right wrist daily and as needed. The order specified for the splint to remain in place for two weeks. On 8/18/24 at 10:05 a.m., Resident #69 was observed in the dining room sitting at a table with other residents. Resident #69 was holding her right hand across her chest. The right hand and wrist were noted to be very swollen and bruised. Resident #69 was rubbing her right hand with an expression of discomfort on her face. She was not wearing a dressing or splint to the right wrist as ordered. On 8/18/24 at 10:10 a.m., in an interview Licensed Practical Nurse (LPN) Staff F said the resident fell and fractured her arm a week ago. Staff F said Resident #69 had a splint, but she would not keep it on. LPN Staff F left the dining room and returned with a medication. She gave the medication to the resident and instructed her to take it for the pain in her arm. The instructions were clearly audible to the other residents sitting at the table. On 8/18/24 at 10:25 a.m., Staff F was observed placing wound supplies on the counter in the dining room. She proceeded to dress Resident #69's incision line to the right wrist in the dining room while the resident was sitting at a table with other residents. Resident #69 became agitated, stood up and attempted to leave the dining room. Staff F stood in the doorway, blocked the resident's exit and applied an ace wrap to the resident's right hand and wrist. Staff F said she wrapped the resident's arm to prevent her from picking at the sutures. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the clinical record revealed Resident #23 had an admitted [DATE]. Diagnoses included dementia, major depressive disorder, mood disorder, anxiety disorder and insomnia. On 8/18/24 at 9:37 a.m., Resident #23 was observed in the dining room of the memory care unit after the breakfast meal. Resident #23 was barefoot and was not able to respond appropriately to simple interview questions. On 8/18/24 at 10:48 a.m., Resident #23 was observed standing barefoot at the nurse's station with no shoes or socks on her feet. When asked about her socks and shoes, Resident #23 mumbled and began to walk back to the dining room. On 8/19/24 at 8:35 a.m., Resident #23 was observed wandering on the memory care unit with mismatched socks (one green, and one yellow) on. She wandered past staff who made no attempt to assist her with wearing matching socks. On 8/19/24 at 9:14 a.m., Resident #23 was observed during breakfast in the dining room of the memory care unit. Resident #23 was walking from table to table and grabbing food items from other residents' plates. Two Certified Nursing Assistants (CNAs) were in the dining room and did not redirect Resident #23 as she continued to take food from other residents. On 8/19/24 at 9:24 a.m., in an interview CNA Staff A said, She does it all the time, as Resident #23 continued to go from table to table taking other residents' food from their plates. CNA Staff A walked over to the resident and redirected her. Resident #23 was observed wandering out of the dining room and into other residents' rooms taking their personal items. Staff did not redirect the resident. On 8/21/24 at 12:24 p.m., Resident #23 was observed walking in the memory care unit with a Certified Nursing Assistant. Resident #23 was wearing mismatched (one blue and one yellow) socks. The Director of Nursing was present during the observation and verified Resident #23 was wearing mismatched socks.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of facility policy and procedure and staff interview the facility failed to provide housekeeping and maintenance services to ensure a clean, safe and comfortable environment for 9 (Rooms #302, #304, #306, #307, #308, #309, #310, #312, and #313) of 13 rooms and the dining room of the memory care unit. The findings included: The facility policy M-200 Maintenance effective 11/30/14 documented the facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair. On 8/18/24 at 12:36 p.m., observation of the Memory Care Unit with the Regional Director of Maintenance (RDM) revealed: The Memory Care Unit had a strong musty odor with a foul smell of urine, and feces. The RDM verified the presence of the strong foul odor and said he would have housekeeping address the issue. room [ROOM NUMBER]: The ceiling tile above the toilet in the bathroom had a layer of thick black substance. The bathroom mirror was missing. room [ROOM NUMBER]: Exposed wires were coming from the wall and electrical outlet box. The RDM said they were cable wires and said they should be capped. Photographic evidence obtained. room [ROOM NUMBER]: The closet doors were missing. Photographic evidence obtained. Exposed wires were sticking out of the wall. The toilet paper holder was broken and missing the front covering. Photographic evidence obtained. room [ROOM NUMBER]: The closet door was missing. Photographic evidence obtained. room [ROOM NUMBER]: The cover plate of the paper towel holder in the bathroom was missing, and plastered areas on the wall needed to be painted. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room [ROOM NUMBER]: The paper towel holder and toilet paper holder in the bathroom were missing the front covers. Photographic evidence obtained. The closet doors were missing. Photographic evidence obtained. There were exposed wires coming from an outlet on the wall. Photographic evidence obtained. There were white plaster patches on the wall in need of paint. Photographic evidence obtained. room [ROOM NUMBER]: There was a large hole in the wall under the sink in the bathroom. Photographic evidence obtained. The closet doors were missing. room [ROOM NUMBER]: The closet doors were missing. room [ROOM NUMBER] A: The closet was missing the handles and did not close properly. Photographic evidence obtained. The wood molding was pulled away from the entrance wall in the dining room, exposing large cracks. Photographic evidence obtained. The Regional Maintenance Director confirmed the findings observed during the tour and verified the identified areas of concerns needed to be addressed. On 8/20/24 at 9:00 a.m., in an interview Registered Nurse (RN) Staff R said staff are supposed to write areas in need of repair in the maintenance book. On 8/20/24 at 9:15 a.m., in an interview RN Staff I said the facility did not have a Maintenance Director for a while, and the previous one did not fix anything. On 8/20/24, review of the maintenance repair request log showed the last maintenance request was dated 6/27/24.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 25618 Based on record review, and resident and staff interviews, the facility failed to ensure the Baseline Care Plan (BCP) was provided to the resident and their representative with a summary of the BCP that included but was not limited to the initial goals of the resident, a summary of the resident's medications and dietary instructions, and any services and treatments to be administered by the facility and any updated information for 2 (Residents #4 and #26) of 3 residents reviewed for BCP. The findings included: On 8/18/24 at 12:58 p.m., during an interview Resident #4 said she was admitted to the facility from an acute care hospital in April 2024. She said when she was admitted to the facility, she didn't remember attending an initial care plan meeting or receiving a copy of her BCP explaining to her the plan of care she would be provided while at the facility. A review of Resident #4's clinical record revealed an admitted [DATE]. Diagnoses included End Stage Renal Disease, Oral Dysphagia (Difficulty swallowing), Chronic Diastolic Heart Failure and Weakness. Further review of Resident #4's clinical record revealed no documentation Resident #4 received a copy of her baseline care plan as required. On 8/21/24 at 8:54 a.m., in an interview the Assistant Minimum Data Set (MDS) Coordinator said she was responsible to initiate, review and update each resident's plan of care during their stay at the facility. She said the admitting nurse or someone from the nursing staff were required to initiate a baseline interim plan of care for all newly admitted residents to ensure there were no delays in implementing interventions in order to ensure all areas of concerns were addressed immediately after their admission to the facility. She said the baseline care plan was given to the resident or their representative within a few days of their admission to the facility by the nursing department prior to the initial care plan meeting after the resident admission to the facility. The Assistant MDS Coordinator confirmed Resident #4 was admitted to the facility on [DATE]. She said after she reviewed Resident #4's clinical record she was unable to find documentation Resident #4 or her legal representative had received a copy of the baseline care plan explaining the initial goals for Resident #4 with the initial goals of the resident, a summary of the resident's medications and dietary instructions, and any services and treatments to be administered by the facility. On 8/21/24 at 9:21 a.m., in an interview Unit Manager Staff G said when a resident is admitted to the facility, their admitting nurse was responsible to complete a baseline care plan which then was signed by the resident and then placed in the resident's clinical record. The next morning the baseline care plan was reviewed during the morning meeting by the interdisciplinary team (IDT), updated as needed, and a copy of the BCP with the initial goals of the resident, a summary of the resident's medications and dietary instructions, any services and treatments to be administered by the facility, and updated information was given to the resident or resident presentative. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 9:35 a.m., in an interview Staff G said she reviewed Resident #4's clinical record and confirmed Resident #4 was admitted to the facility on [DATE]. She said Resident #4's initial admission assessment was completed by the admitting nurse on 4/17/24. She said she was unable to find documentation Resident #4's BCP was completed. She stated she was also not able to find documentation Resident #4 or her legal representative received a copy of the BCP with the initial goals of the resident, a summary of their medications and dietary instructions, and any services and treatments as required. On 8/18/24 at 12:19 p.m., during an interview Resident #26 said she was admitted to the facility on [DATE]. She did not remember attending a care plan meeting when she was admitted to the facility. She further said she was not given a copy of her BCP and did not know what goals and interventions were put in place to assist in her recovery when she was admitted . A review of Resident #26's medical record revealed she was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease, Weakness, History of Falls, Wheezing, Pain and Malignant Neoplasm of the Liver. Further review of Resident #26's clinical record revealed no documentation Resident #26 had received a copy of her BCP as required. On 8/21/24 at 9:15 a.m., in an interview the Assistant MDS Coordinator confirmed Resident #26 was admitted to the facility on [DATE]. She said after she reviewed Resident #26's clinical record she was unable to find documentation an initial care plan meeting was held with Resident #26 within the required time frame. She further said she was unable to find documentation Resident #26 and/or her legal representative had received a copy of the BCP explaining the initial goals for Resident #26 with the initial goals of the resident, a summary of the resident's medications and dietary instructions, and any services and treatments to be administered by the facility. On 8/21/24 at 9:50 a.m., in an interview Unit Manager Staff G said she was able to locate a copy of Resident #26's BCP, in the BCP binder in the conference room. She said after reviewing Resident #26's BCP located in the BCP binder, she noted it was not signed by Resident #26 as required. She further said she was unable to find documentation Resident #26 or their representative had received a copy of the BCP with the initial goals of the resident, a summary of their medications and dietary instructions, and any services and treatments as required. On 8/21/24 at 10:10 a.m., in an interview the Director of Nursing said when a resident was admitted to the facility, the admitting nurse was responsible to complete the BCP and review the information with the resident at that time. She said the baseline care plan was then reviewed by the IDT the next morning for any needed updates and the resident was provided a copy of the BCP with the initial goals of the resident, a summary of their medications and dietary instructions, and any services and treatments as required. She confirmed Residents #4 and #26 had not received a copy of their BCP with the initial goals, a summary of their medications and dietary instructions, and any services and treatments as required.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, family and staff interview, review of facility policy and procedure, and record review the facility failed to ensure they provided an ongoing program to support the residents in their choice of activities which are designed to meet the resident's interests and support the resident physical, mental and psychosocial well-being for 6 (Residents #10, #23, #48, #69, #79 and #96) of 21 residents reviewed for involvement in the activity program on the secured memory care unit. The findings included: The facility policy Community Life Overview effective date 11/1/21 documented Activity programs are developed and implemented to meet the individualized physical, mental, and psychosocial /emotional needs of the resident as well as promoting self-expression of choice. Activities refer to any endeavor other than routine activities of daily living in which a resident participates that enhances his/ her sense of well-being and that promotes or enhances physical, cognitive, and emotional health. Review of the August 2024 activity calendar for the memory care unit documented the following activities: 8/18/24 at 10:30 a.m., Courtyard time. 1:00 p.m., Hydration. 2:00 p.m., Socialize with friends. 8/19/24 at 10:00 a.m., Courtyard time. 10:30 a.m., Hydration. 2:30 p.m., massage/lotion. 3:00 p.m. Fall Craft. 8/20/24 at 10:00 a.m., Courtyard time. 10:30 a.m., Hydration. 2:30 p.m., Sing-along. 3:00 p.m. fruit cup. 1. Review of the clinical record revealed Resident #10 had an admitted [DATE]. Diagnoses included repeated falls with major injuries, Alzheimer's disease, anxiety, major depressive disorder and dementia. The Annual Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) dated 3/6/24 documented the resident's daily preferences, included listening to music, being around pets, keeping up with the news, and religious services were somewhat important to the resident. Participating in things with a group of people, doing your favorite activities, and going outside to get fresh air were very important to Resident #10. The MDS noted Resident #10's cognitive skills for daily decision making were severely impaired. On 8/18/24 at 10:08 a.m., Activity Aid Staff H was not adequately supervising five residents engaged in a coloring activity in the dining room of the secured memory care unit. Resident #10 and four other residents were seating at a table in the dining room with crayons and coloring books. Resident #10 picked up a crayon and put it into her mouth and took a bite of the crayon. Upon request, Staff H intervened and retrieved the crayon from the resident's mouth. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/18/24 at 12:10 p.m., and 8/19/24 at 2:29 p.m., Resident #10 was observed in the dining room of the memory care unit. The television (TV) was on at times playing music. No structured activities were in progress. There were no items of interest at the table for Resident #10 and the other residents seated in the dining room. 2. Review of the clinical record revealed Resident #23 had an admitted [DATE], with diagnoses including dementia, major depressive disorder, mood disorder, anxiety disorder and insomnia. The Quarterly MDS dated [DATE], documented the behavior wandering occurred daily. The MDS noted Resident #23's cognitive skills for daily decision making were severely impaired. The care plan initiated 4/7/21, (revised 2/25/24) specified Resident #23 was dependent on staff for meeting emotional, intellectual, physical and social needs due to cognitive deficits. The goal for Resident #23 was for her to maintain involvement in cognitive stimulation, and social activities as desired. The interventions for Resident #23 specified to encourage resident participation in activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities such as listening to music, coloring, and simple puzzles. Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility. On 8/18/24 at 9:20 a.m., and 12:21 p.m., Resident #23 was observed wandering on the unit, going in and out of the dining room. Staff did not redirect the resident. There was no structured activity in progress. On 8/19/24 at 9:21 a.m., Resident #23 was observed in the dining room wandering from table to table as other residents were having breakfast and the staff did not redirect her. On 8/20/24 at 12:02 p.m., Resident #23 was observed in the dining room wandering to other tables and taking food and drinks from other residents plates. There was no staff intervention provided. On 8/20/24 at 1:55 p.m., Resident #23 was observed wandering in and out of other residents' rooms taking their personal items. The staff on the secured unit did not redirect the resident or offer an activity. 3. Review of the clinical record revealed Resident #48 had an admitted [DATE] with diagnoses including major depressive disorder, anxiety disorder, dementia, seizures and macular degeneration. The care plan revised 7/12/24 identified Resident #48 was dependent on staff for meeting emotional, intellectual, physical and social needs due to cognitive deficits. The care plan goal for Resident #48 was to maintain involvement in cognitive stimulation, social activities as desired through next review. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan interventions specified for staff to assist the resident to engage in simple, structured activities such as listening to music, coloring, simple puzzles, and structured arts and crafts. Encourage Resident participation in scheduled activities, engage in simple structured activities. On 8/18/24 at 10:05 a.m., Resident #48 was observed sitting at the dining room table for over one hour. Her back was to the TV, and she had nothing in front of her to provide mental or physical stimulation. There was no group activity in progress. On 8/18/24 at 10:54 a.m., in an interview Resident #48's family member said, The only issue I have on the secured memory unit is the residents sit a lot. There are no activities. All they do here is sit or wander. On 8/18/24 at 12:00 p.m., and 8/19/24 at 9:39 a.m., Resident #48 was observed wandering on the unit, ambulating in and out of the dining room and in the hallways with no intervention or redirection provided. There was no activity in progress and 13 residents who reside on the unit were sitting in the dining room. On 8/20/24 at 2:00 p.m., Resident #48 was observed ambulating on the unit, wandering back and forth in the hallway with no purpose or direction. There was no activity in progress. 4. Review of the clinical record revealed Resident #69 had a readmitted [DATE] with diagnoses including vascular dementia, anxiety disorder, Alzheimer's disease, restlessness and agitation. The Quarterly MDS dated [DATE] identified the resident had the behavior of wandering occurring daily. The MDS noted Resident #69's cognitive skills for daily decision making were severely impaired. On 8/18/24 at 10:11 a.m., Resident #69 was observed sitting in the dining room at a table. Activity aid Staff H was with a group of 4 residents coloring at a table. She said Friday 8/16/24 was her first day and she did not know any of the residents on the memory care unit. Music was playing on the TV. Residents were wandering in and out of the dining room. On 8/18/24 at 5:11 p.m., in a phone interview Resident #69's family member said I come on weekends to visit and there are never any activities. The residents just sit and do nothing in the dining room, or they get up and wander and no one stops them or does anything with them. It is a small unit, do something with the residents, but they do nothing. On 8/19/24 at 8:40 a.m., Resident #69 was observed sitting at a table in the dining room, her had her right sleeve pulled up and was observed picking at the sutures on her right wrist from a recent surgical procedure. There was no dressing in place. The skin surrounding the wound was red and there was an area that was missing the top layer of skin. No intervention was made to redirect the resident. Resident #69 then got up from and table and ambulated out of the dining room without anyone redirecting her. On 8/19/24 at 10:09 a.m., Resident #69 was observed wandering unsupervised on the unit. On 8/19/24 at 3:00 p.m., Resident #69 was observed in the dining room sitting at a table. The TV was on, but her back was facing the TV. Activity aid Staff D was at a table making paper chains. Four residents of the 11 residents in the dining room were involved with the activity. There were no books or other items offered to the 11 residents who were not participating in making paper chains. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of the clinical record revealed Resident #79 had a readmitted [DATE] with diagnoses including dementia, chronic diastolic heart failure, adjustment disorder, and falls. Review of the Admission MDS dated [DATE] documented listening to music you like and doing things with groups of people were somewhat important to the resident. While getting fresh air and going outside were very important. The MDS noted Resident #79's cognitive skills for daily decision making were severely impaired. The care plan revised on 7/12/24 identified Resident #79 was an elopement risk/wanderer due to dementia with impaired safety awareness. The resident wandered aimlessly. The goal for Resident #79 was to demonstrate happiness with daily routine. The interventions instructed to provide structured activities, walking inside and outside, reorientation, strategies including signs, pictures and memory boxes. On 8/18/24 at 10:04 a.m., Resident #79 was observed seated at a table with another resident. The TV was on but Resident #79 was not able to see the TV from her seat. Activity Aid Staff H was in the dining room coloring with four residents at a table. She did not attempt to engage Resident #79 in the coloring activity or offer an alternative. On 8/18/24 at 10:35 a.m., Resident #79 was observed in her wheelchair wandering on the memory care unit. There was no activity in progress. On 8/18/24 at approximately 10:40 a.m., in an interview Staff H said, Let's see what I can get for everyone, and left the unit. Staff H returned with a pitcher of juice and offered small amounts to the residents in the dining room. On 8/20/24 at 1:08 p.m., in an interview Certified Nursing Assistant(CNA) Staff E said Resident #79 was able to walk with a walker when she wants but uses the wheelchair daily. She doesn't really do anything. Staff E said sometimes the resident will sit in the dining room during an activity, or she will wander. Resident #79 was observed seated at a table in the dining room with her back towards the TV. On 8/20/24 at 2:00 p.m., Resident #79 was observed seating at the same spot at the table with no activity in progress. In an interview Resident #79 said there was nothing going on and she liked some things to do. 6. Review of the clinical record revealed Resident #96 had an admitted [DATE] with diagnoses including dementia, adjustment disorder, depression, and mood disorder. Review of the admission MDS dated [DATE] documented going outside for fresh air was very important to the resident. (continued on next page)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan initiated on 5/3/24 identified Resident #96 was an elopement risk, and wanderer due to dementia. The goal for the resident was her safety will be maintained. The interventions instructed to provide structured activities, walking outside, and reorientation strategies including signs, pictures and memory boxes. On 8/18/24 from 9:30 a.m., to 10:37 a.m., during observation on the memory care unit, Resident #96 was observed wandering on the unit with no redirection from the staff and no activity program in progress. Resident #96 walked over to the dining room and slammed the door shut loudly. The nurse seated at the desk looked at the resident and made no attempt to redirect her. Resident #96 continued to wander on the unit, using obscenities and talking to herself very loudly. Music was playing in the dining room, but no staff were present. On 8/19/24 at 9:29 a.m., in an interview Licensed Practical Nurse (LPN) Staff C said Resident #96 was on one-to-one supervision because of her behaviors. Staff C said the day before on 8/18/24, Resident #96 struck another resident's family member. Staff C said Resident #96 had episodes of hitting other residents but never a visitor. On 8/19/24 at 9:45 a.m., Resident #96 was observed wandering the halls with a CNA, there was no structured activity is in progress. On 8/19/24 at 2:36 p.m., the observation of staff not providing activities listed on the activity calendar for the memory care unit on 8/18/24 and 8/19/24 was reviewed with the Activity Director. In an interview the Activity Director (AD) said she has two part time activity aids, one started two days ago. She said the activity Courtyard time was on the calendar daily but had not happened in a month or so. She said it was too hot outside, and the residents did not want to go outside. The AD confirmed she did not change the calendar to replace the activity. The AD said Hydration was listed as an activity and not part of the resident's daily care because the activity aid will sit and talk to the residents, it's not just give them juice and go. The AD said she was going to have her assistant go to the memory care unit now. She said when she has group activities only four to eight of the 21 current residents stay for the activity. She said she did not do anything special for the wandering residents on the unit. On 8/19/24 at 2:53 p.m., Activity Aid Staff D was on the memory care unit seated in the dining room with a group of four Residents making a paper chain. Staff D said three residents came to the activity and left. She said it was usually the group that participates in activities. Eight other residents were observed seating in the dining room not participating in the activity. Several other residents were observed wandering in the hallway, going in and out of the dining room. Staff D said she worked 22 hours a week and was responsible for all the activities in the facility. She said, I try to do everything on the calendar but some days I just don't get to all three of the units. The only time I can get the wandering residents to stay in the dining room for an activity is if it involves snacks. There were no activities, books or other items offered to the other residents seated in the dining room. Staff D confirmed she did not do any activity for the residents who wander on the unit.

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	106000	A. Building B. Wing	08/21/2024

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 41155 Based on review of facility job description and staff interviews, the facility failed to ensure the activities program was directed by a qualified professional who is a qualified therapeutic recreation specialist or an activity professional. This has the potential to affect all current residents who participate in activities. The findings included: The facility Job Description for Director of Therapeutic and Recreational Services documented The primary purpose of the director of therapeutic and recreational services (activity director) position is to plan organize develop and direct the overall operation of the activity department in accordance with current federal state and local standards guidelines and regulations our established policies and procedures and as may be directed by the executive director to ensure that an ongoing program of activities is designed to meet in accordance with the comprehensive assessment the interest and the physical mental and psychosocial well-being of each resident. Education: Must possess a minimum of bachelor's degree in therapeutic recreation or equivalent training /experience. Experience: Must possess a minimum of two years' experience in therapeutic recreation. On 8/20/24 at 11:27 a.m., a request was made to Human Resources for a copy of the Activity Director's qualifications/certificates. On 8/20/24 at 11:33 a.m., the Human Resources Director (HRD) provided the Activities Director employee file and verified the lack of documentation the current Activities Director had the required qualifications for the position. The HRD said the acting Activity Director Staff B was in training to get her certification and was working under the direction, and supervision of the Administrator. The HRD said Staff B has been the Activity Director for several months but did not have a certification in therapeutic activities. The HRD said Staff B accepted the position after the previous Activity Director left but she did not know the exact date the previous Activity Director had left. The HRD confirmed nothing in the employee file showed Staff B met the requirement for the Activities Director position. On 8/20/24 at 11:54 a.m., in an interview the Administrator confirmed Staff B has been the Activity Director Staff for more than six months without the required qualifications for the position.

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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. 37256 Based on observation, record review and interview the facility failed to implement resident-directed care and treatment per physician order and professional standards of practice for 1 (Resident #502) of 2 residents reviewed for wound care which could place the resident at risk for infection or worsening of wound. The findings included: Facility Policy & Procedure titled Clinical Guideline Skin and Wound, document name WC-100 effective date 4/1/17 indicated licensed nurse to complete skin evaluation weekly and document in the medical record, licensed nurse to document presence of skin impairment/new skin impairment when observed and weekly until resolved, Monitor residents response to treatment and modify treatment as indicated. On 8/18/24 at 9:40 a.m., Resident #502 was observed lying in bed with a bandage to his right wrist area dated 8/16. On 8/20/24 at 9:30 a.m., Resident #502 was observed lying in bed with a bandage to his right wrist area dated 8/18. On 8/20/24, review of Resident #502's clinical record revealed a change in condition note dated 8/5/24 noting Resident #502 had a skin tear to the dorsal area of the right arm. The Primary Care Provider Feedback was blank. It did not list recommendations, testing or orders for the skin tear. The care plan initiated on 8/5/24 documented a skin tear on the resident's left arm related to fragile skin. The interventions included to monitor, document location, size and treatment of the skin tear. On 8/20/24 at 9:30 a.m., in an interview Registered Nurse (RN) Staff M said Resident #502 scratched himself about a week prior and had a skin tear. Staff M said the doctor was notified and the bandage was there, so they changed it every day. On 8/20/24 at 9:35 a.m., the Director of Nursing who observed the bandage to the resident's right wrist and verified it was dated 8/18. On 8/20/24 at 9:45 a.m., Licensed Practical Nurse (LPN) Unit manager Staff G also observed the bandage to the resident's right wrist dated 8/18. She said there was an order for wound care. Upon reviewing the electronic clinical record, Staff G said she could not locate a wound care order for the skin tear to the resident's wrist. On 8/20/24 at 12:00 p.m., in an interview the Director of Nursing (DON) said there was nothing documented about the wound to the right wrist on the skin sheets. She said there was no progress notes describing the wound, stage of healing or condition. The DON said they needed an order to be performing wound care.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, record review, review of facility's policy and procedure, staff, and family interview the facility failed to implement a systemic approach to identify risk factors and implement appropriate supervision and interventions to prevent avoidable falls with serious injuries for 3 (Resident #10, #69 and #30) of 5 residents sampled with falls or fall related injuries. The findings included: The facility policy N-1259 Fall Management documented Residents are evaluated for fall risk. Patient centered interventions are initiated based on resident risk. A fall refers to unintentionally coming to rest on the ground floor or other lower level but not as the result of an overwhelming external force (e.g. resident pushes another resident). An episode where a resident lost his or her balance and would have fallen if not for another person or if he or she had not caught him or herself is considered a fall unless there is evidence suggesting otherwise when a resident is found on the floor a fall is considered to occur. Purpose: Is to identify residents at risk for falls and establish or modify interventions to decrease the risk of a future fall and minimize the potential for a resulting injury. 1. Review of the clinical record revealed Resident #10 was admitted to the facility from an acute care hospital on 3/1/23 after a fall and fall related fractures to the nasal bones, right maxilla, facial bone and right radius (forearm) fracture. Admitting diagnoses included difficulty walking, dementia, anxiety, repeated falls and Alzheimer's disease. The Annual Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) dated 3/6/24 documented the resident ambulated independently. The MDS noted Resident #10's cognitive skills for daily decision making were severely impaired. The Fall Risk Evaluation dated 5/13/24 documented a score of 50 indicating the resident was at a low risk for falls. The care plan initiated 12/26/23 revised 4/18/24 identified Resident #10 was at risk for further falls and fall related injuries due to decreased physical mobility, poor communication/comprehension, unaware of safety needs, and dementia. The goal was to minimize risk of minor injury through next review. The interventions included anticipate and meet the resident's needs. Physical Therapy to evaluate and treat as ordered or as needed. Be sure call light is within reach and encourage the resident to use it. Bed in low position. Review of the nursing progress note dated 5/13/24 at 11:40 a.m., documented Resident #10 had a fall hitting the back of her head causing bleeding, fell in the doorway of [room #]. She was transferred to the local emergency room for evaluation. Per emergency department fracture nose. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note on 5/13/24 at 11:45 a.m., documented resident with swelling, bruising and bleeding to face. Rt [Resident] walked into [room #] to visit another resident. She was walking out and fell . She hit her face on the floor causing, bruising, swelling and bleeding. 911 was called and Rt transferred to the ER [emergency room]. Results of x ray showed fracture of the nose. Resident returned to facility on 5/13/23. The emergency room discharge paperwork documented diagnosis: closed fracture of nasal bone, contusion of chest wall and fall. The Fall Investigation Form dated 5/13/24 provided by the facility noted the unwitnessed fall happened during the 7:00 a.m., to 7:00 p.m. shift. Resident #10 was found laying face down in the hallway. The form did not list the time of the fall. The interview section of the form noted: Resident: Why they think the fall happened: Maybe I was pushed. First Responder: Location: Hallway; What happened: Fall; Why they think the fall happened: Resident slipped on items on floor. The form listed the root causes as lack of safety awareness, anxiety, walkway unclear. The updated intervention was to educate staff to ensure walkways are clear. Review of the only witness statement obtained from Licensed Practical Nurse (LPN) Staff C documented Resident #10 went into [Room #], the resident in [Room #] told her to get out of the room. She was walking out of the room and fell hard on the floor. She landed on her face; her nose was bleeding. I called 911. The witness statement did not document how the information for the unwitnessed fall was obtained. There was no documentation the facility considered Resident #10's statement that maybe she was pushed as a possible cause of the fall. The care plan was updated on 5/14/24 after the fall with the new intervention, Inservice staff to keep hallways/walkways clear of clutter. Requests for the education provided to staff, resident nursing notes and fall assessments were not provided at the time the survey ended. On 8/21/24 at 12:07 p.m., in an interview LPN Staff C said she was the only one on the floor at the time of the resident's fall on 5/13/24. Staff C said Resident #10 went into (Room #) and she feel in the doorway. Resident #10 said the resident in the room pushed her but the resident she said pushed her was in the bathroom at that time. Staff C said there was a sheet on the floor and she thinks Resident #10 may have tripped on it. She said she spoke with the other resident who said she just told Resident #10 to get out of her room but denied pushing her. Staff C said, We have a lot of wandering residents on this unit and some of them go into other residents' rooms. She said Resident #10 is always saying someone pushed her but she has never seen that. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/21/24 at 12:39 p.m., in an interview the Director of Nursing (DON) said she was at the facility and completed the investigation when Resident #10 fell and broke her nose. She said Resident #10 said she was pushed but she always says she was pushed, regardless of what happens to her. She said she has never witnessed anyone pushing Resident #10. She likes to be by herself and is afraid other residents will take her things. She said Resident #10 always carries her things with her because she is afraid someone is going to take what's hers. The DON said, We do have residents who get into verbal yelling matches because it is a secured dementia unit. We do have wandering residents who like to take things from other resident rooms. When asked about the unwitnessed fall, the DON said, As for the fall, no one pushed her. There was something on the floor a blanket or sheet and she slid on it and fell . 2. Review of the clinical record revealed on 8/9/24 Resident #69 sustained a fall resulting in a right wrist fracture requiring surgical intervention. Resident #69 was readmitted to the facility on [DATE]. Diagnoses included vascular dementia, anxiety disorder, Alzheimer's disease, restlessness and agitation. The Quarterly MDS dated [DATE] documented the resident had daily wandering behavior. The MDS noted Resident #69's cognitive skills for daily decision making were severely impaired. The care plan initiated 11/26/21 and revised 11/29/23 identified the resident was at risk for falls due to incontinence, unaware of safety needs, wandering and attempts to stand unassisted. The goal for the resident was to minimize the risk of falls. The interventions specified, Anticipate and meet the resident's needs. Ensure that the resident is wearing appropriate foot ware/nonskid socks when ambulating or mobilizing in w/c (wheelchair). On 8/9/24 the care plan was updated with the interventions to, Perform medication review. Resident sent to ER for eval per MD (Physician) orders. The intervention were to be implemented upon readmission to facility. On 8/18/24 at 10:05 a.m., Resident #69 was observed in the dining room sitting at a table s holding her right hand with the left across her chest. Her right hand and wrist were noted to be very swollen and bruised. Resident #69 has an expression of discomfort on her face with furrowed brow and was rubbing the right hand. On 8/18/24 at 10:10 a.m., in an interview LPN Staff F said the resident fell approximately a week ago and fractured her arm. Staff F said she did not know exactly when or how the resident fell and sustained the fracture. Staff F said Resident #69 had an order for a splint to the right hand but she would not keep it on. On 8/18/24 at 10:14 a.m., Resident #69 was observed at a table in the dining room with grip sock on. Resident #69 stood up unassisted from the table and left the dining room unsupervised. Resident #69 was observed wandering the hallway without staff supervision or redirection. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/18/24 at 5:09 p.m., in a telephone interview Resident #69's family member said she did not understand why Resident #69 keeps falling. She said the resident had dementia and wanders. She said, She will wander and will walk until she is fatigued, but they just let them do whatever they want on that unit. They don't do activities. The residents just sit or they walk. No one pay attention. The family member said last year Resident #69 had broken fingers and sutures to her hand but no one could tell her how or why it happened. She said then last October Resident #69 had a broken hip and they did not know what happened. They just told said she had pain when she was ambulating. The family member said, I don't care if you have dementia, if you break a hip you are going to yell out in pain. She said now she broke her wrist, had to have surgery again and once again no one could tell me what happened. She said when Resident #69 returned from the hospital, she told the nurse it was very important to keep the stiches covered and the doctor said she needed to keep the brace on her arm. She said on 8/15/24 the nurse called and said the splint was missing and no one could locate it. She said the surgical incision also looked infected and they contacted the physician for an order for antibiotics. The family member said, I am very upset right now over all of this. It is a small unit for dementia residents. Who is supervising them? On 8/19/24 at 8:38 a.m., in an interview LPN Staff C said on the day Resident #69 broke her wrist I found her sitting on the floor in room [ROOM NUMBER] (not her room) yelling. I knew her arm was broken; I could tell right away. I called the physician and we sent her to the emergency room . She said she did not know where the resident's splint was. She said she was off for two days. When she came back to work on 8/15/24 the splint was missing. They searched for the splint and could not find it. Staff C said, she won't keep it on anyway. She takes it and the dressing off. On 8/19/24 at 8:40 a.m., Resident #69 was observed sitting at a table in the dining room. She had her right sleeve pulled up and was picking at the sutures on the right wrist. There was no dressing in place. The skin surrounding the wound was red and there was an area that was missing the top layer of skin. Staff in the dining room did not intervene or redirect the resident from picking at the sutures. Resident #69 got up and exited the dining room. On 8/19/24 at 10:09 a.m., Resident #69 was observed wandering unsupervised on the unit. Her gait was noted to be very unsteady. On 8/19/24 at 3:18 p.m., review of the incident log revealed 28 incidents of falls from 12/1/23 through 8/19/24 in the secured unit. On 8/19/24 at 4:21 p.m., a meeting was held with the Administrator, the DON, and the Regional Nurse Consultant to discuss Resident #69's fall and supervision necessary to prevent avoidable falls. Resident #69's care plan for falls revised on 11/29/23 noted the risk for falls was related to incontinence, unaware of safety needs, wandering, attempts to stand unassisted. The care plan noted at times the resident refused staff assistance with ambulation. The interventions listed included a medication review (8/9/24), anticipate the resident's needs (11/26/21), and ensure the resident is wearing appropriate footwear/non-skid socks when ambulating or mobilizing in wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The care plan did not include adequate supervision to prevent avoidable falls and fall related injuries. The Administrator, the DON, and the Regional Nurse Consultant verified the care plan did not include specific measures, including necessary supervision to prevent avoidable falls. On 8/20/24 at 12:22 p.m., in an interview Unit Manager LPN Staff G said she was the manager for B wing and C wing (Memory Care Unit). She said, I go to the memory care unit daily, but the majority of my time is spent on B wing because it is the skilled unit. There are two CNA's, and one nurse assigned for each shift on the secured unit. We don't do anything special for the wandering residents except to try and redirect them to activities but most of them don't sit. The Unit Manager said when she is not on the unit, the nurse is responsible to supervise the unit. On 8/20/24 at 12:49 p.m., in an interview CNA Staff E said when a resident is wandering, they just go, you can't always get them to sit. They get up and they walk, and you try and redirect them but most of them do not do anything, there is nothing back here for them to do. With Resident #69 you can sit her down and she will get right back up. On 8/20/24 at 1:00 p.m., in an interview the DON said Resident #69 does not keep the dressing or anything on the right wrist. She will not sit down and when she does it is only for short periods. She is up and down all the time. She does not sit for activities. On 8/20/24 at 4:48 p.m., in an interview the Regional Nurse Consultant said the facility had no policy to address the needs for the residents on the memory care unit and no policy indicating the requirements for placement on the unit. 37256 3. Resident #30 was admitted [DATE] with diagnosis to include muscle wasting and atrophy, unspecified dementia, longstanding persistent atrial fibrillation, sick sinus syndrome, repeated falls and unsteadiness on feet. The care plan for falls initiated on 7/15/24 noted Resident #30 was at risk for falls related to confusion, incontinence, unaware of safety needs and wandering. The goals were to minimize risk for falls, minimize risk of minor or serious injury and minimize the side effects of medication contributing to increasing residents fall risk. The interventions included to educate the resident/resident's representative/caregivers about safety reminders and what to do if a fall occurs, ensure that the resident is wearing appropriate footwear/nonskid socks when ambulating and physical therapy evaluate and treat as ordered or as needed. The Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #30 had a severe cognitive impairment and MDS section E for behaviors indicated Resident #30 exhibited Wandering behavior daily. A change of condition progress note dated 8/3/24 at 8:38 p.m. indicated Resident #30 had a fall and was sent to the emergency room (ER) for evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the incident report created 8/3/24 at 10:15 p.m., indicated the Certified Nursing Assistant notified the nurse Resident #30 was lying on the floor. The Nurse arrived and observed resident sitting up against the wall. Injuries were noted to left eyebrow, left arm skin tear. The resident was limping on the left side when tried to walk. Review of the ER discharge paperwork for encounter date 8/3/24 located in the chart revealed she had received stitches to the injury on the left eyebrow. A progress note dated 8/4/24 at 07:10 am noted: while walking at the hallway resident lost her balance and fell , hitting her head. Resident was wearing nonskid sock. Head to toe assessment done, resident placed on neuro checks. Resident returned back to ed x 2 persons. MD and family notified. Review of the incident report created 8/4/24 at 7:10 a.m., had the same information as progress note and indicated Resident #30 sustained an abrasion to top of scalp, but was not taken to the hospital. A progress note dated 8/5/24 at 5:51 p.m. noted: Resident was walking in the hallway by the nurses. She turned around fast and lost her balance and fell . She hit the left side of her forehead on the floor causing a hematoma. She has no other signs of injury. Moves all extremities normally. Alert and oriented x 1 as is normal for this resident . Resident was transported to Hospital ER for evaluation. Review of the incident report created 8/5/24 at 5:35 p.m., indicated same information as progress note and indicated Resident #30 was sent to the hospital for evaluation of hematoma on left upper forehead. Review of the ER discharge paperwork for encounter date 8/5/24 located in the chart revealed she was discharged from the ER with a primary encounter diagnosis of Fall and closed head injury. A progress note dated 8/5/24 at 11:58 p.m. noted: While sitting at the nursing we heard a thump. Went into Resident #30's room saw resident face down on the floor on the L side of her bed. Blood was coming from the L side of her head. Resident was transferred to her bed from the floor and assessed for other injuries. None noted. Unable to obtain vitals as resident fighting . Received order to send resident to ER. 911 called. Review of the incident report created 8/5/24 at 11:10 p.m., indicated same information as progress note and indicated Resident #30 was taken to the hospital with a laceration to the top of her scalp. Review of the hospital paperwork for encounter date 8/6/24 located in chart revealed Resident #30 had been admitted to the hospital for critical care management of a subarachnoid hemorrhage. Resident #30 did not return to the facility. On 8/19/24 at 2 p.m., LPN Staff C said Resident #30 was very demented and had fallen several days in a row. Staff C explained Resident #30'stypical behavior was she could be resistant to care and liked to do things her way. She said Resident #30 could walk well, had nonslip socks and wandered a lot. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/19/24 at 2:05 p.m. Staff E Certified Nurse Assistant (CNA) said Resident #30 used to wander around a lot, room by room, and she would mess up everything in the other residents room. Staff E said when she did that they just told the nurse. Staff E said she wasn't aware of any interventions for falls for Resident #30, nor did she have bedside mats. On 8/19/24 at3:39 p.m., LPN Staff F said Resident #30 wandered all day, room to room digging in stuff, taking clothes from one room to another. She said sometimes Resident #30 would sit down for a few minutes but then she would get up and just go again. Staff F said Resident #30 did have fall mats or a scoop mattress. She said Resident #30 was not one to stay still, unless she was tired she would go lay down, but she was always active wandering around. On 8/19/24 12 p.m., the Director of Nursing (DON) said Resident #30 was identified as a fall risk/wandering in her care plan. DON said somehow it was a miss with implementing any interventions specific to Resident #30 for falls/wandering. DON said in their analysis of Resident #30's falls they identified part of the root cause was she had no fall interventions in place for her falls and wandering behavior.

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Aspire on Evans	3735 Evans Ave Fort Myers, FL 33901

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25618 Based on observation, record review, and resident and staff interviews, the facility failed to ensure 1 (Resident #17) of 1 resident reviewed for dental services received appropriate care and services for broken teeth. The findings included: On 8/18/24 at 10:51 a.m., in an interview with Resident #17, she said she had not been seen by the dental hygienist for several months and she didn't know why she was not receiving routine dental care. She also said the dentist told her several months ago, she could get partial dentures to replace her broken teeth, but no one had told her when that would occur. Review of Resident #17's medical record revealed she was admitted to the facility on [DATE]. The medical record contained documentation Resident #17 was seen by the dental hygienist on 10/26/22 and 11/23/22. An updated dental service plan was signed by a nurse. On 8/21/24 at 8:30 a.m. in an interview with the Social Worker Regional Director (SWRD), she said currently the facility does not have a full time Social Service Director (SSD), and she and other SSD have been filling in until the new one would be starting the last week in August 2024. She said part of the SSD responsibilities was to ensure the coordination of all ancillary services which included dental, podiatry, and vision were implemented in a timely manner. The SWRD said she did not know if Resident #17 was currently receiving dental service and would have to review Resident #17's medical record and call the dentist's office for any missing documentation. Review of the Dental Services Policies and Procedures effective 11/30/14 and revised on 11/27/17 stated the center would contract with a dentist licensed by the Board of Dentistry to provide routine and 24-hour emergency dental services. The nurse or designee would if necessary or if requested assist the resident in making the appointment and arranging for transportation to and from the dentist's office. On 8/21/24 at 11:06 a.m., in an interview with SWRD, she said after reviewing Resident #17's medical record, speaking with Resident #17 and the dentist's office, and reviewing dental office progress notes, she was able to determine Resident #17 did not receive routine dental cleaning by the hygienist in 2024. She provided documentation the dentist had seen Resident #17 on 4/26/24 and documented the patient (Resident #17) had upper and lower natural teeth. The patient was interested in extraction of her broken teeth and receiving partials dentures. The SWRD said the facility's Social Service Director should follow up with the dentist's office for the approval of the extractions and for the partial dentures. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SWRD said she was unable to find documentation the facility's SSD had followed up with the dentist's office for approval for the broken teeth extractions and for the partial dentures for Resident #17 as noted on the dental progress note dated 4/26/24. She said she was unable to find documentation the SSD coordinated with the dentist and Resident #17 to ensure Resident #17 received the new partial dentures in a timely manner as required.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44824 Based on observation, staff interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in long term care facilities in a safe and sanitary manner. The findings included: The facility policy titled Food Storage: Cold Foods Policy last revised 2/2023 states all time/temperature control for safety foods, frozen and refrigerated, will be appropriately stored in accordance with the guidelines of the FDA Food Code. Procedures include: All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. The Equipment Policy provided by facility stated, All foodservice equipment will be clean, sanitary, and in proper working order. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials; All staff members will be properly trained in the cleaning and maintenance of all equipment; All food contact equipment will be cleaned and sanitized after every use; All non-food contact equipment will be clean and free of debris; the dining services Director will submit requests for maintenance or repair to the Administrator and/or Maintenance Director as needed. On 8/18/24 at 9:15 a.m., the Initial kitchen tour was conducted with the Dietary Manager who said he has been at the facility since January 2024. The following were observed: Unlabeled and undated food items, including a meat in a storage bag were stored in the walk-in refrigerator. The Manager verified the observation and said without a label he could not tell what the food was. He said it probably was leftovers from the previous night but couldn't tell. Photographic evidence obtained. Dietary Aide Staff J was observed washing dishes using the dishwasher. The Manager said the dishwasher was originally a high temp dishwasher. They were unable to fix it so it was converted to a low temp sanitizing dishwasher. In an interview Staff J said she has used the dishwasher almost every day since she started work at the facility six months ago but has never been shown how to use the test strips to test the sanitizer. She said she did not know how to test and ensure the dishwasher had the appropriate amount of sanitizing agent. Review of the dishwasher's log for August 2024 showed Staff J's initials for 8/18/24 and several other days. No entry was documented for the sanitizer, only the water temperature. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dietary Staff K was observed testing the sanitizer in the dishwasher. The test strip bottle's label was worn off, the expiration date was not legible. The values for the sanitizing agent was not legible making it impossible to verify the test strip results to the value listed on the bottle. The Dietary Manager verified the label of the test trip bottle was worn out making it impossible to read the expiration date and compare the test strip to the value listed on the label. The Dietary Manager discarded the bottle of test strips. Photographic evidence obtained. Two large black plastic covers covered in dust and debris were observed stored on the bottom shelf of the steam table located in the kitchen. The Manager picked up the covers and showed that they were the lids used to cover the clean plates in the plate rack. The ceiling tiles and air conditioning vents over the food preparation area and the clean dish storage were dirty, dusty, and covered in black bio growth. The Manager said the maintenance department was in charge of cleaning the vents and he did not know the last time they were cleaned. There was also a missing ceiling tile and stained dark area on another tile by entryway. Photographic evidence obtained. On 8/19/24 at 10:00 a.m., in an interview the Representative from the company who converted the high temp dishwasher to a low temp sanitizing dishwasher said the dishwasher was made to be used as a high or low temp dishwasher. He said he maintains the dishwasher and that it is working appropriately. He said the staff had only been checking the water temperature of the dishwasher and not the sanitizer. On 8/21/2024 at 1:30 p.m., in an interview the Maintenance Director said he has been employed at the facility for three months now. He said he cleaned the air conditioning vents and ceiling tiles in the kitchen after the observation made on 8/18/24. He said it was maintenance's responsibility to check and clean them monthly, but he has been too busy since he started employment at the facility. He said he did not know the last time the vents and tiles were cleaned.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50970 Based on observation, clinical record review, review of facility's policy and procedure and staff interviews, the facility failed to determine and implement appropriate transmission-based precautions for 1(Resident #8) of 1 resident reviewed for transmission-based precautions. The findings included: Facility policy titled Influenza, Prevention and Control of Seasonal. 2001 MED-PASS, Inc. (Revised October 2019) Policy Statement reads this facility follows the current guidelines and recommendations for the prevention and control of seasonal influenza. Page 4, Antiviral Medication and Chemoprophylaxis are administered to residents and staff when appropriate, and in accordance with CDC guidelines. Page 5, said, Infection Precautions contact, and droplet precautions are implemented for residents with suspected or confirmed influenza for seven (7) days after illness onset or until 24 hours after the resolution of fever and respiratory system, whichever is longer. Precautions may be applied for longer periods based on clinical judgement. The CDC guidance includes the following Patients with flu should be placed on droplet precautions for 5 days after the onset of their illness. Droplet precautions are necessary when a patient is within three to six feet of another person, as infections can be transmitted through air droplets by coughing, sneezing, talking, and close contact with the patient's breathing. Place patients in a private room. If private rooms are not available, you can cohort patients who are suspected of having the flu together.) Review of the clinical record revealed Resident #8 was admitted to the facility on [DATE]. Diagnoses included Diabetes, Dementia, Shizoaffective Disorder and Hypertension. Her BIMS (Brief Interview for Mental Status) was 12/15 which indicates intact cognition. Record review revealed on 8/14/24 at 3:41 p.m., Resident #8 was sent via Ambulance to the hospital for evaluation of chest pain, cough, and elevated blood sugar. Resident #8 returned on 8/14/24 with a diagnosis of Influenza. Resident # 8 was placed in a double occupancy room with a roommate. The progress note dated 8/14/24 at 3:41 p.m. read, Resident is currently in bed complaining of chest pain, and nonproductive cough. Her blood sugar was 525 when the nurse took it. ARNP (Advanced Registered Nurse Practitioner) was notified, new order to send resident out to ER (emergency room) for evaluation due to high blood sugar, nonproductive cough, and chest pain. The progress note for 8/14/2024 at 10:29 p.m. documented the resident returned via transport in a wheelchair and was assisted by staff into her bed. Resident refused all her scheduled medications, she reported that she was tired and going to bed. The resident came back with no new orders. The discharge paperwork noted diagnoses of 1) Fever 2) Cough 3) Parainfluenza infection. Progress Notes dated 8/15/24 at 4:48 p.m. by Staff L, Unit Manager states Resident #8 returned from hospital last night with a diagnosis of Parainfluenza 3. Currently on contact precautions until symptoms subside. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician order dated 8/18/24 at 7:00 p.m., specified to place Resident #8 on Droplet Precautions due to Parainfluenza 3 every shift until 8/25/24. As of 8/21/24 there have been no further nursing progress notes for Resident #8. The Care Plan initiated on 8/18/24 noted, Resident #8 has influenza. The interventions included: Droplet precautions; Encourage good fluid intake and offer residents favorite beverages; Give antipyretics and analgesics as ordered for fever and pain; Monitor for signs and symptoms of dehydration; Monitor labs and report abnormal findings to physician. On 8/18/2024 at 1:26 p.m., Resident #8's door was observed closed with a sign on it that said, Contact Precautions. Chart review showed documentation the resident was positive for Influenza. On 8/19/2024, Clinical record revealed Resident#8 was now on transmission based. A droplet precaution sign was on the door. Resident #8 continued to reside in the same room as Resident #40. PPE (Personal Protective Equipment) was observed in a bin outside of Resident #8's door. Resident was observed dressed and sitting at bedside in her wheelchair. She was on oxygen and still has a cough. On 8/20/24 at 11:14 a.m., during an interview the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) Resident #8 Resident #8 was supposed to be placed on Droplet Precaution and placed in a private room. The ADON said, it just didn't happen, it was supposed to happen, but it didn't. She said it was miscommunication between the Unit Manager and the Director of Nursing (DON). On 8/21/24 at 10:25 a.m., during a joint interview with the Unit Manager and DON, the DON said she did not have any input in the care of Resident #8. She said it was the Infection Preventionist's duty to regulate residents on Transmission Based Precautions. She was unaware that Resident #8 should have been placed in a private room based on the facility's policy. The Unit Manager told her the Regional Director of Nursing told her to place Resident #8 on Contact Precautions on 8/19/24. She said she was not aware Resident #8 needed a private room. On 8/21 24 at 10:45 a.m., in an interview the Regional Nurse said on 8/19/24 the Unit Manager asked her for guidance. She told the Unit Manager to put Resident #8 on Contact precautions and call the physician for further orders. She said she did not place Resident #8 in a private room because she thought she was asymptomatic. She said she did not refer to the facility's infection control policy.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 25618 Based on staff interviews and record review the facility failed to ensure 5 facility Staff (E, N, O, P, and Q) out of 5 facility staff nursing aids reviewed, had the required in-service training for continuing competency education of no less than 12 hours per year. Failure to provide staff with continuing yearly in-service training on a yearly basis could lead to staff not having knowledge and training on how to provide the appropriate services to resident with cognitive impairments. The findings included: On 8/21/24 a review of Staff E, Certified Nursing Aid (CNA) employee files revealed she was hired 5/5/08. Further review revealed no documentation, Staff E had completed a minimum of 12 hours of continuing competency education in 2023, as required on a yearly basis. On 8/21/24 a review of Staff N, CNA employee files revealed she was hired 5/24/05. Further review revealed no documentation, Staff E had completed a minimum of 12 hours of continuing competency education in 2023, as required on a yearly basis. On 8/21/24 a review of Staff O, CNA employee files revealed she was hired 8/29/01. Further review revealed no documentation, Staff E had completed a minimum of 12 hours of continuing competency education in 2023, as required on a yearly basis. On 8/21/24 a review of Staff P, CNA employee files revealed she was hired 1/23/07. Further review revealed no documentation, Staff E had completed a minimum of 12 hours of continuing competency education in 2023, as required on a yearly basis. On 8/21/24 a review of Staff Q, CNA employee files revealed she was hired 4/8/21. Further review revealed no documentation, Staff E had completed a minimum of 12 hours of continuing competency education in 2023, as required on a yearly basis. On 8/21/24 at 12:38 a.m., in an interview with Human Resource Director (HRD) confirmed the hire dates for Staff E, Staff N, Staff O, Staff P, and Staff Q. She further said she was unable to find documentation Staff (E, N, O, P, and Q) had completed the required competency education/in-services for 2023. On 8/21/24 at 12:48 a.m., in an interview with HRD and Assistance Director of Nursing (ADON)/Staffing Coordinator, she said the CNAs were required to complete a minimum of 12 hours of continuing competency education on a yearly basis, between January through December of each year. The HRD said she would routinely send email reminders throughout the year to the CNAs, reminding them to complete their mandatory competency education training on educational portal on the computer. The HRD said she thought the ADON was responsible to ensure the CNAs were completing their mandatory competency education/in-services on a yearly basis. The ADON/Staffing Coordinator said, she was not responsible to monitor the CNAs mandatory competency education/in-services on a yearly basis. She thought the HRD was monitoring the CNAs education/in-services because she was sending the reminders to the CNAs to complete their mandatory yearly education in the education portal on the computer. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The HRD and ADON said they were unable to find documentation Staff E, Staff N, Staff O, Staff P, and Staff Q had completed a minimum of 12 hours of continuing competency education for the calendar year of 2023 as required.