STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106017	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Palma Sola Bay	6305 Cortez Rd W Bradenton, FL 34210

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39249 Based on interviews and record review, the facility failed to protect the resident's right to be free from abuse/neglect by 1) failing to respond to a serious change in condition in a timely manner for one resident (#404) out of seven residents sampled for abuse/neglect and, 2) use of a Geri-chair as a restraint to limit a residents movement for one resident (#248) out of seven sampled for abuse/neglect. Resident #404 experienced a change of condition secondary to bleeding from four skin wounds on his arms and legs, which began on [DATE] at 1:00 p.m. The bleeding required four dressing changes to the upper extremities and two dressing changes to the lower extremities due to bleeding through the dressings over the course of 17 hours. On [DATE] at 7:25 a.m. Resident #404 was transferred to the hospital and subsequently died from widespread sepsis and bleeding caused by DIC (disseminated intravascular anticoagulation [a rare but serious condition that causes abnormal blood clotting throughout the body's blood vessels]). The resident was not provided the care and services to benefit from earlier assessment and treatment from a higher level of care. This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and or death to Resident #404 and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to a D after verification of removal of immediacy of harm. Findings included: 1. On [DATE] at 4:15 p.m. an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) to review a reportable incident for Resident #404. The DON stated she was familiar with Resident #404, and she could speak to the investigation conducted at the time of the incident. The DON stated a family member complaint was received on social media. The DON stated they investigated and did not find any problem with the care. The DON stated Resident #404 was not compliant with care and had displaced a wound vac. She stated Resident #404 was in and out of the hospital and the last time he was sent to the hospital he passed away. The DON stated Resident #404 was sent to the hospital due to bleeding, and he had saturated the dressings on his arms. The DON stated the resident was on Eliquis as a blood thinner, and the family member complained that the resident was not sent to the hospital soon enough. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the medical record revealed Resident #404 was admitted on [DATE] with diagnoses, including but not limited to, cerebral infarction due to thrombosis of right middle cerebral artery, chronic pancreatitis, unspecified open wounds to left ankle, neck, right lower leg, right thigh, left hip, left lower leg, lower back, and pelvis without penetration to retroperitoneum (the tissue that lines the abdominal wall and covers most of the organs in the abdomen), unspecified atrial fibrillation, gastrostomy status, unspecified gastrointestinal hemorrhage, unspecified anemia, and unspecified coagulation defect. A review of the Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #404 had a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition. A review of the Order Summary Report for Resident #404 revealed the following: [DATE] Full Code. [DATE] Labs: CBC (complete blood count), CMP (comprehensive metabolic profile) one time only for admission labs for one day. [DATE] Aspirin 81 tablet chewable 81 MG (milligrams) give one tablet by mouth one time a day for DVT (deep vein thrombosis) prevention. [DATE] Eliquis oral tablet 5 MG (Apixaban) give one tablet by mouth two times a day for coagulopathy. [DATE] Furosemide oral tablet 80 MG give one tablet by mouth two times a day for pleural effusion. [DATE] Left hip cleanse with normal saline, silver nitrate dampened gauze, and place border dressing every day shift every Tuesday and Friday for wound. [DATE] Left lateral ankle change wound vac every Tuesday and Friday, apply black granulofoam, set section to 125 MMHG (millimeters/mercury) every day shift every Tuesday and Friday for wound. [DATE] Mid thoracic back cleanse with normal saline, xeroform, and place border dressing every day shift for wound. [DATE] Right heel cleanse with normal saline, apply skin prep, leave open to air every day shift every other day for DTI (deep tissue injury). [DATE] Left lateral ankle change wound vac, apply black granulofoam, set suction to 125 MMHG one time only for wound care for one day. [DATE] Right heel cleanse with normal saline, apply skin prep, leave open to air every night shift every other day to DTI. [DATE] Mid thoracic back cleanse with normal saline, xeroform, and place border dressing every night shift for wound. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] Left ischium cleanse with normal saline, apply medihoney, then cover with mepilex every day shift every other day for wound care. [DATE] Left lateral ankle and mid back change wound vac every Monday and Thursday, apply black granulofoam, set suction to 125 MMHG, connect with Y-tubing every day shift every Monday and Thursday for wound. [DATE] Cleanse skin tear to left elbow apply TAO (triple antibiotic ointment) and DSD (dry sterile dressing) until healed then discontinue every night shift for skin tear care. [DATE] Cleanse skin tear to upper leg apply TAO and DSD until healed then discontinue every night shift for skin tear care. [DATE] Zofran oral tablet 4 MG (Ondansetron) give one table by mouth every six hours as needed for nausea/vomiting. [DATE] CBC, CMP one time only for bleeding for one day. [DATE] Send to ER (emergency room) for evaluation one time only for bleeding for one day. A review of the Comprehensive Care Plan, initiated on [DATE], for Resident #404 revealed the following: Focus: The resident is on anticoagulant/anti-platelet therapy related to atrial fibrillation and CVA (cardiovascular accident). Revision [DATE]. Goal: The resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date. Interventions: Administer anticoagulant medications as ordered by physician. Monitor for side effects and effectiveness every shift. Daily skin inspection. Report abnormalities to the nurse. Monitor/document/report as needed adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Focus: The resident has a skin tear to left elbow and left leg. Initiated on [DATE]. Goal: The resident's skin tear will show signs of healing by review date. Interventions: Monitor/document location, size, and treatment of skin tear. Report abnormalities. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Progress Notes for Resident #404 revealed the following: -[DATE] 10:17 a.m. Physician progress note: Patient is seen today for follow-up visit. It was reported by staff that he had a fall last night and hit his head. He was sitting on the side of the bed and was trying to position himself back to lying down when he fell over. He did not ask for help or use call light. Patient states he was having hallucinations and confused after he hit his head. The incident was not reported until this morning. Patient is on Eliquis and Aspirin, so he was sent out to the ER for a CT (computed tomography scan) of the head. He did receive multiple skin tears on his arm and leg. He also has a bruise/redness on his face. -[DATE] 10:50 a.m. Nursing progress note: Resident heard calling out, resident observed on side of bed holding onto bed on right side and bedside table to the left side. Resident was in between. Resident assisted back to bed and care provided. ROM [range of motion] WNL [within normal limits]. No s/s [signs/symptoms] of acute distress. Routine pain med given, and wound care provided to skin tears. -[DATE] 7:51 a.m. Nursing progress note: Patient observed to have dislodged/saturated dressing to LUE [left upper extremity] at start of shift, changed patients dressing per physicians order. after receiving PM [evening] medications dressings observed to be saturated again, cleaned wounds to LUE and R [right] forearm and applied ABD [abdominal] pads with krelix [sig] and ace wrap on top to apply pressure. Patient c/o [complains of] nausea and prior emesis,, administer PRN [as needed] Zofran to good effect. Notified physician at 2130 of patients saturation of dressings and treatment applied. Physician ordered for dressing to stay in place until am then to be removed for assessment and CBC to be drawn on [DATE]. At approximately 0630 dressing was removed with some saturation through the ace wrap with the gauze noted to be heavily saturated. Notified physician and received order to send to ER to evaluation and to control bleeding .Called 911 at 0714 upon entering room at approximately 0725 with EMS [emergency medical services] patient had emesis in container dark brown with some red noted approximately 100 ML [milliliter] in container, Resident left facility with EMS at approximately 0730 via stretcher, notified patients emergency contact A review of the Treatment Administration Record (TAR), dated [DATE]-[DATE], for Resident #404 revealed the following: Cleanse Skin tear to left elbow apply TAO and DSD until healed every night shift for skin tear documented as completed once on [DATE]. Cleanse skin tear to left upper leg apply TAO and DSD until healed every night shift for skin tear care documented as completed once on [DATE]. A review of the Medication Administration Record (MAR), dated [DATE]-[DATE], for Resident #404 revealed the following: Aspirin 81 MG give one tablet by mouth one time a day for DVT prevention documented as administered on [DATE] at 9:00 a.m. Eliquis oral tablet 5 MG give one tablet by mouth two times a day for coagulopathy documented as administered on [DATE] at 9:00 a.m. and 5:00 p.m. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Furosemide oral tablet 80 MG give one tablet by mouth two times a day for pleural effusion documented as administered on [DATE] at 9:00 a.m. and 5:00 p.m. Zofran oral tablet 4 MG give one tablet by mouth every six hours as needed for N/V not documented as given on [DATE]. On [DATE] at 5:49 p.m., a telephone interview was conducted with a Family Member (FM) of Resident #404. The FM stated Resident #404 transferred from the hospital to the facility in March and seemed to be getting better. The FM stated the resident went to the hospital for an abscessed tooth. The FM stated she went to see Resident #404 every day and stayed with him all day long at the facility. The FM stated she would have a good friend drive her there and pick her up. The FM stated on [DATE] she escorted the resident to the courtyard to smoke and when she put her hand on the handle of the wheelchair she picked up her hand to find it full of blood. She stated that was a few days before Resident #404 died . The FM stated the resident was bleeding from his leg, arm, and shoulder area. The FM stated the shoulder was sopping with blood, and she took the dressing off and went in to the facility to get someone to put something over the area. The FM stated the nurse started yelling at Resident #404 for taking off the dressing. She stated then someone came in and put a dressing on the area. The FM stated she had seen the Resident #404 throwing up blood during the day in his urinal. The FM stated she went to the nursing station and asked the nurse to please call EMS and get an ambulance to come. The FM stated when she told the nurse Resident #404 was bleeding out the staff all started laughing and said they wouldn't let him bleed out. She stated the nurse never went down to check on the resident at all. She stated her friend was with Resident #404 in the room and saw him take two sips of water and throw up blood in the urinal. The FM stated it was close to 7pm [DATE], the day before he went to the hospital. The FM stated the next morning she got a call from a man who said he sent Resident #404 to the hospital because he was bleeding out. The FM stated when she got to the hospital, Resident #404 was on life support, and they had to keep giving him blood. The FM stated the nurse never left the nurse's station the night she was there to go in and check on Resident #404 from the time she asked for the resident to go to the hospital until the time she left the facility. On [DATE] at 07:06 p.m., an interview was conducted with Staff A, Licensed Practical Nurse (LPN). She stated she remembers the resident, and mentioned the mother visited daily. She confirmed she was the assigned nurse to Resident #404 on [DATE] day shift a.m. to 7 p.m. She stated she remembered he was bleeding while in the courtyard with his FM. She stated the resident told her he took his bandages off so he could let them breathe. She stated after he returned inside the facility, she applied dressings to both upper extremities. Staff A stated she informed the oncoming nurse for the night shift. She stated during her shift she changed the dressings twice because of visible blood and saturation through the dressings. She stated she used a kerlix roll dressing. She stated she thought she changed it around ,d+[DATE] p.m., then prior to shift change at 7 p.m. it needed to be changed again. She stated the FM was on the patio with the resident while he was smoking. Staff A stated she let the night nurse know Resident #404 was bleeding from his arms. She stated she reported she had re-wrapped the arms. She stated it was unusual to have to change the dressings twice. She stated she did not call the doctor. She stated Resident #404 had quite a few wounds and she had changed one on his leg and his wound vac. She stated the wound vac had quite a bit of drainage and had an odor to it. She stated she did not recall any nausea or vomiting. She stated she really was not thinking about the resident being on blood thinners. She stated she did not make any notes, do a change of status, or notify the doctor of the need to change dressings due to bleeding. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 7:29 p.m., an interview was conducted with Staff O, RN (Registered Nurse, Unit Manager). She stated Resident #404 was admitted from the hospital but unable to recall the specifics of his admission. She stated Resident #404 had a lot of different wounds. She said his FM visited almost every day. She stated she knew the resident was sent out for a bleed. She stated she was told there were allegations of neglect because of an on-line review. She stated she did not participate in the investigation and stated abuse investigations are generally completed by the DON/NHA. She stated the nurses are expected to document changes in condition and notify the physician in the medical record. She stated if a resident's family asked for them to be sent to the hospital the nurses are supposed to do so and let the doctor know what is happening. On [DATE] at 9:22 a.m., an interview was conducted with Staff P, LPN (Licensed Practical Nurse). He stated he knew Resident #404 had falls, skin tears and could be grumpy, but did not recall Resident #404's plan of care. He stated Resident #404 had dressings all over, had a lot of skin tears, and a wound vac to his sacrum. The nurse stated in report he was told while the FM visited with the resident in the courtyard, the resident was picking at his dressings, and (Staff A) told him she had just changed his dressings. He stated he did not recall (Staff A) saying that was the second time she had to change the dressings. He stated, After report around 7:45 p.m., I saw the dressing on his left arm was not really on but the mepilex dressing had some bleeding on it. I'm not sure who transferred the resident back to bed but there was some blood smeared on the wall by his bed. I changed the dressings to his arms and legs all at once and cleaned the blood off the wall. When giving him his night meds [9:00 p.m.], I saw the dressings on his upper arms were saturated and the current dressing was not appropriate for the amount of bleeding. The dressing was red in color. The dressing to his legs were not saturated. I changed the dressings on his legs. I applied ABD, Kerlix and pressure dressings to his arms. I changed all the dressings [legs and arms] to have a timeline of how much he was bleeding. I used gauze pads on his legs, because they were absorbent and easy to see changes. I notified the MD about 9:30 p.m. and he said to leave the dressings in place and draw a CBC [[DATE]] and leave those dressings in place until the morning and then to remove them for assessment. I rounded on him to make sure there was no visible bleeding throughout the shift. The nurse stated he did not remove the ace wrap during the night to keep pressure on the arms. He stated about 6:00 a.m. he removed the ace wrap and saw the wound had bled through to the ace and Resident #404 told him he had vomited on the prior shift. Staff P, LPN stated the previous nurse had not reported the resident had vomited. On [DATE] at 11:02 a.m. an interview was conducted with the Primary Care Physician (PCP) for Resident #404. The PCP stated he did not recall specifically being notified about Resident #404 on [DATE]. He stated if he was notified for the first time that a resident was having a bleeding episode he would have told them to monitor and apply a pressure dressing. He stated he did not recall being contacted during the day shift about any bleeding the resident was having. He stated if he was told of previous episodes of bleeding and multiple changes of dressings he would have told them to send the resident out to be evaluated. He stated it was not ideal that the nurses did not notify him of multiple dressing changes, and he would have expected them to report any vomiting of blood as well. The PCP stated if he had been aware of the bleeding wounds and vomiting blood, he would have sent him out. He stated what he was told was not the same as what occurred. He stated his partner admitted Resident #404 to the hospital and the resident died of sepsis with complications. He stated the resident had fungus in the blood cultures. He stated he reviewed the chart in the hospital and Resident #404 had DIC, his platelets dropped, and the resident passed away. He stated he usually investigates the reason if a resident passes away because he wants to know what happened. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Disseminated intravascular coagulation, or DIC, is a complicated condition that can occur when someone has severe sepsis or septic shock. Both blood clotting and difficulty with clotting may occur, causing a vicious cycle. Small blood clots can develop throughout your bloodstream, especially in the microscopic blood vessels called capillaries. This blocks the blood flow to many parts of your body, including your limbs and your organs. Blood is then not able to bring oxygen and nutrients to the tissues. On the reverse side of the cycle, DIC can increase bleeding. The body uses up so many of the blood clotting proteins for the multiple blood clots in the blood vessels that there are not enough left to clot the blood elsewhere. Several medical conditions can cause DIC, including sepsis. DIC affects about 35% of patients who have sepsis. Sepsis, which was often called blood poisoning, is the body's life-threatening response to infection. Like strokes or heart attacks, sepsis is a medical emergency that requires rapid diagnosis and treatment. (Sepsis Alliance, Sepsis and Disseminated Intravascular Coagulation. 2023. https://www.sepsis.org/sepsisand?disseminated-intravascular-coagulation-dic/) On [DATE] at 11:23 a.m. an interview was conducted with Staff Q, CNA (Certified Nursing Assistant). The CNA stated she remembered Resident #404 and she provided care for him often. She stated a FM came to see the resident almost every day. She stated she remembered the resident vomiting a lot and bleeding from the dressings. She stated the resident always asked for pain medications. She stated she would clean up the resident and empty his urinal because he would vomit in it. She stated she always reported vomiting to the nurse, but she did not document that in the medical record because there is no place for them to do that, she stated she left that for the nurse to do. She stated she did recall him having bleeding and vomiting before he went to the hospital, and she told the nurse, but she does not recall if the nurse went in to check on the resident. She described the bleeding and vomiting as dark brown. She stated the only reasons Resident #404 would call was to be changed, have his dressings changed, vomiting, or taking pain pills. On [DATE] at 8:07 p.m. an interview was conducted with a Family Friend (FF), who would transport the FM to and from the facility and visit with Resident #404. The FF stated he would take the FM to visit Resident #404 nearly every day and he was present at the facility on [DATE] the weekend before Resident #404 passed away. He stated when he saw Resident #404 on the evening of [DATE] the resident was coherent and he had bruises all over, blood on his sheets, and blood on the walls in his room. He stated he and the FM where in the room with Resident #404 for about an hour and a half. The FF stated he got the resident a glass of water, but the resident was not able to keep it down and he was throwing up blood. He stated they informed the nurses. The FF stated if the resident took a drink of water he would throw up blood in less than a minute and it was dark red. The FF stated Resident #404 asked him to take him to the hospital to avoid getting charged any money and he told him he couldn't take him because of his medical needs. The FF stated he went to the hallway and told a lady nurse that Resident #404 was throwing up blood and she was just like oh ok. He stated the nurse did not go to the room to see what was going on. He stated he has really tried to block the whole incident out of his memory. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility policy titled Anticoagulant Therapy, revised on [DATE], revealed the following: Procedure: -Obtain physician's order for anticoagulant therapy and labs. -Alert lab -Initiate anticoagulant flow sheets or electronic equivalent -Post lab results on flow sheet or electronic equivalent, indicating date -Identify resident and explain therapy -Perform hand hygiene -Document the time, dose administration on MAR and anticoagulant flow sheet/ electronic equivalent -Monitor the resident for signs of bleeding. *Observe for hematoma development or excessive bleeding or bruising. *Test stool, urine, emesis for Guaiac/Hemoccult as ordered by physician. *Monitor labs per physician's order. *Use pressure-dressing PRN until bleeding stops. *Perform hand hygiene. *Document in the medical record. Note-Residents requiring Coumadin (Warfarin) administration should have lab work drawn as ordered by the physician to determine effectiveness of therapy and subsequent dosages. A review of the facility policy titled Notification of Change in Condition, revised on [DATE], revealed the following: Policy: The Center to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is a change in the status or condition. Procedure: -The nurse to notify the attending physician and Resident Representative when there is a(n): (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Accidents *Significant change in the patient/resident's physical, mental, or psychosocial status *Need to alter treatment significantly -New treatment -Discontinuation of a current treatment due to but not limited to: *Adverse consequences *Acute condition *Exacerbation of a chronic condition *A transfer or discharge of the Patient/Resident from the Center *Patient/Resident consecutively refuses medication and/or treatment (i.e. two or more times) *Patient/Resident is discharged without proper medical authority -In the event of an emergency situation, 911 to be called and the attending physician and the Resident Representative to be notified as soon as possible. -The nurse to complete an evaluation of the Patient/Resident. Document evaluation in the medical record. -The nurse will contact the physician. In the event that the attending physician does not respond in a reasonable amount of time, the Medical Director may be contacted. -If the Medical Director does not respond, call 911 and document in the medical record. -Notify the patient/resident and the resident representative of the change in condition. Document notification in the medical record. -Document resident/patient change in condition on 24 hour report -Complete SBAR as indicated 2. On [DATE] at 10:33 a.m. Resident #248 was observed lying in a geriatric chair by the entrance to the courtyard and facing the nurses' station. On [DATE] at 12:33 p.m. Resident #248 was observed upright in a geriatric chair with a family member assisting him with his meal. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 03:05 p.m. an interview was conducted with Resident #248's. The family member said Resident #248 likes to sleep in a quiet area and he is always placed by the nurses' station which is noisy. On [DATE] at 8:32 a.m. an interview and observation was conducted with Resident #248. Resident #248 was sitting in a geriatric chair facing the nurses' station. He said he does not necessarily like sitting at the nurses' station I would rather go to my bed A review of Resident #248's admission records showed he was admitted to the facility on [DATE], with diagnoses to include traumatic brain injury, Parkinson's Disease, dementia, and seizures. Review of Resident #248's five-day Minimum Data Set (MDS), dated [DATE], Section C- Cognitive Patterns revealed a Brief Interview for Mental Status (BIMS) score of four indicating severe cognitive impairment. A review of Resident #248's order summary report, dated [DATE] showed orders to include: full activity and may have restorative/ maintenance program as indicated. A review of Resident #248's active care plan, initiated [DATE], showed the resident had an actual fall with minor injury related to unsteady gait. The interventions include place resident in common areas, initiated [DATE]. On [DATE] at 12:16 p.m. an interview was conducted with the Director of Rehabilitation (DOR) he said the use of geriatric chairs can decrease resident function .and it is not an ideal intervention to prevent falls. On [DATE] at 1:39 p.m. an interview was conducted with Staff G, Licensed Practical Nurse (LPN) Resident #248's nurse. Staff G, LPN said the use of the geriatric chair is because Resident #248 is a fall risk and can get up from the chair when the footrest is lowered. Staff G confirmed Resident # 248 cannot independently get out the geriatric chair. On [DATE] at 2:40 p.m. an interview was conducted with the Director of Nursing (DON), she said resident #248 was placed in the geriatric chair for comfort. The DON said the geriatric chair's restriction on Resident #248, it did not cross my mind and is not ideal. On [DATE] at 8:00 p.m. Resident #248 was observed with eyes closed and laying in a geriatric chair facing the nurses' station. On [DATE] at 08:15 a.m. Resident #248 was observed with eyes closed and laying in a geriatric chair facing the nurses' station. A review of the facility policy titled Abuse, Neglect, Exploitation & Misappropriation, revised on [DATE], revealed the following: Policy: (continued on next page)

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Aspire at Palma Sola Bay	6305 Cortez Rd W Bradenton, FL 34210

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	It is inherent in the nature and dignity of each resident that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse. Employees of the center are charged with a continuing obligation to treat residents, so they are free from abuse, neglect, mistreatment and/or misappropriation of property. No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and/or misappropriation of property against any resident. Violation of this standard will subject employees to disciplinary action, including dismissal, provided herein. [.] Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include but are not limited to: -Failure to provide adequate nutrition and fluids. -Failure to take precautionary measures to protect the health and safety of the resident. -Intentional lack of attention to physical needs including, but not limited to, toileting and bathing. Failure to provide services that result in harm to the resident, such as not turning a bedfast resident or leaving a resident in a soiled bed. -Failure or refusal to provide a service for the purpose of punishing or disciplining a resident, unless withholding of a service is being used as part of a documented integrated behavioral management program. -Failure to notify a resident's legal representative in the event of a significant change in the resident's physical, mental or emotional condition that a prudent person would recognize. -Failure to notify a resident's legal representative in the event of an incident involving the resident, such as failure to report a fall or conflict between residents that result in injury or possible injury. -Failure to report observed or suspected abuse, neglect or misappropriation of resident property to the proper authorities. -Failure to adequately supervise a resident known to wander from the facility without the staff knowledge. Note: Such things as failure to comb a resident's hair on occasion would not necessarily constitute a reportable incidence of neglect. However, continued omission in providing daily care and/or failure to address and resolve the omission could constitute neglect. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[.] Involuntary seclusion is defined as separation of the resident from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident representative. [.] Procedure: [.] Non-action, which results in emotional, psychological, or physical injury, is viewed in the same manner as that caused by improper or excessive action. All actions in which employees engage with residents must have the legitimate goal, the healthful, proper, and humane care and treatment of the resident. [.] 5. Investigation The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A Social Service representative may be offered in the role of resident advocate during any questioning of or interviewing of residents. Facility immediate actions to remove the Immediate Jeopardy included: To remove immediacy, the facility has initiated the following as it relates to F600: F600 o As of [DATE], resident (#404) was discharged from the facility to the hospital. o As of [DATE] residents with a BIMS of 10 or greater interviews were initiated to ensure no other allegations of abuse were not reported and investigated. And residents/responsible parties with a BIMS of 9 or less a skin evaluation will be initiated on [DATE] by a licensed nurse. o Licensed Nurses received education beginning on [DATE] on following a change in condition, proper documentation, monitoring, and communication and reporting of a change in condition in a timely manner. o Center Personnel received education beginning on [DATE] on ab [TRUNCATED]

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50836 Based on interviews and record review the facility failed to complete a thorough investigation of an allegation of neglect for one resident (#404) out of seven residents sampled for abuse/neglect. Findings included: On [DATE] at 4:15 p.m. an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) to review a reportable incident for Resident #404. The DON stated she was familiar with Resident #404, and she could speak to the investigation conducted at the time of the incident. The DON stated a family member complaint was received on social media. The DON stated they investigated and did not find any problem with the care. The DON stated Resident #404 was not compliant with care and had displaced a wound vac. She stated Resident #404 was in and out of the hospital and the last time he was sent to the hospital he passed away. The DON stated Resident #404 was sent to the hospital due to bleeding, and he had saturated the dressings on his arms. The DON stated the resident was on Eliquis as a blood thinner, and the family member complained that the resident was not sent to the hospital soon enough. A review of the Order Summary Report for Resident #404 revealed the following: [DATE] Full Code. [DATE] Labs: CBC (complete blood count), CMP (comprehensive metabolic profile) one time only for admission labs for one day. [DATE] Aspirin 81 tablet chewable 81 MG (milligrams) give one tablet by mouth one time a day for DVT (deep vein thrombosis) prevention. [DATE] Eliquis oral tablet 5 MG (Apixaban) give one tablet by mouth two times a day for coagulopathy. [DATE] Cleanse skin tear to left elbow apply TAO (triple antibiotic ointment) and DSD (dry sterile dressing) until healed then discontinue every night shift for skin tear care. [DATE] Cleanse skin tear to upper leg apply TAO and DSD until healed then discontinue every night shift for skin tear care. [DATE] Zofran oral tablet 4 MG (Ondansetron) give one table by mouth every six hours as needed for nausea/vomiting. [DATE] CBC, CMP one time only for bleeding for one day. [DATE] Send to ER (emergency room) for evaluation one time only for bleeding for one day. A review of the Comprehensive Care Plan, initiated on [DATE], for Resident #404 revealed the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: The resident is on anticoagulant/anti-platelet therapy related to atrial fibrillation and CVA (cardiovascular accident). Revision [DATE]. Goal: The resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date. Interventions: Administer anticoagulant medications as ordered by physician. Monitor for side effects and effectiveness every shift. Daily skin inspection. Report abnormalities to the nurse. Monitor/document/report as needed adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Focus: The resident has a skin tear to left elbow and left leg. Initiated on [DATE]. Goal: The resident's skin tear will show signs of healing by review date. Interventions: Monitor/document location, size, and treatment of skin tear. Report abnormalities. On [DATE] at 7:29 p.m., an interview was conducted with Staff O, RN (Registered Nurse, Unit Manager). She stated Resident #404 was admitted from the hospital but unable to recall the specifics of his admission. She stated Resident #404 had a lot of different wounds. She said his FM visited almost every day. She stated she knew the resident was sent out for a bleed. She stated she was told there were allegations of neglect because of an on-line review. She stated she did not participate in the investigation and stated abuse investigations are generally completed by the DON/NHA. She stated the nurses are expected to document changes in condition and notify the physician in the medical record. She stated if a resident's family asked for them to be sent to the hospital the nurses are supposed to do so and let the doctor know what is happening. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:22 a.m., an interview was conducted with Staff P, LPN (Licensed Practical Nurse). He stated he knew Resident #404 had falls, skin tears and could be grumpy, but did not recall Resident #404's plan of care. He stated Resident #404 had dressings all over, had a lot of skin tears, and a wound vac to his sacrum. The nurse stated in report he was told while the FM visited with the resident in the courtyard, the resident was picking at his dressings, and (Staff A) told him she had just changed his dressings. He stated he did not recall (Staff A) saying that was the second time she had to change the dressings. He stated, After report around 7:45 p.m., I saw the dressing on his left arm was not really on but the mepilex dressing had some bleeding on it. I'm not sure who transferred the resident back to bed but there was some blood smeared on the wall by his bed. I changed the dressings to his arms and legs all at once and cleaned the blood off the wall. When giving him his night meds [9:00 p.m.], I saw the dressings on his upper arms were saturated and the current dressing was not appropriate for the amount of bleeding. The dressing was red in color. The dressing to his legs were not saturated. I changed the dressings on his legs. I applied ABD, Kerlix and pressure dressings to his arms. I changed all the dressings [legs and arms] to have a timeline of how much he was bleeding. I used gauze pads on his legs, because they were absorbent and easy to see changes. I notified the MD about 9:30 p.m. and he said to leave the dressings in place and draw a CBC [[DATE]] and leave those dressings in place until the morning and then to remove them for assessment. I rounded on him to make sure there was no visible bleeding throughout the shift. The nurse stated he did not remove the ace wrap during the night to keep pressure on the arms. He stated about 6:00 a.m. he removed the ace wrap and saw the wound had bled through to the ace and Resident #404 told him he had vomited on the prior shift. Staff P, LPN stated the previous nurse had not reported the resident had vomited. On [DATE] at 11:23 a.m. an interview was conducted with Staff Q, CNA (Certified Nursing Assistant). The CNA stated she remembered Resident #404 and she provided care for him often. She stated a FM came to see the resident almost every day. She stated she remembered the resident vomiting a lot and bleeding from the dressings. She stated the resident always asked for pain medications. She stated she would clean up the resident and empty his urinal because he would vomit in it. She stated she always reported vomiting to the nurse, but she did not document that in the medical record because there is no place for them to do that, she stated she left that for the nurse to do. She stated she did recall him having bleeding and vomiting before he went to the hospital, and she told the nurse, but she does not recall if the nurse went in to check on the resident. She described the bleeding and vomiting as dark brown. She stated the only reasons Resident #404 would call was to be changed, have his dressings changed, vomiting, or taking pain pills. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:02 a.m. an interview was conducted with the Primary Care Physician (PCP) for Resident #404. The PCP stated he did not recall specifically being notified about Resident #404 on [DATE]. He stated if he was notified for the first time that a resident was having a bleeding episode he would have told them to monitor and apply a pressure dressing. He stated he did not recall being contacted during the day shift about any bleeding the resident was having. He stated if he was told of previous episodes of bleeding and multiple changes of dressings he would have told them to send the resident out to be evaluated. He stated it was not ideal that the nurses did not notify him of multiple dressing changes, and he would have expected them to report any vomiting of blood as well. The PCP stated if he had been aware of the bleeding wounds and vomiting blood, he would have sent him out. He stated what he was told was not the same as what occurred. He stated his partner admitted Resident #404 to the hospital and the resident died of sepsis with complications. He stated the resident had fungus in the blood cultures. He stated he reviewed the chart in the hospital and Resident #404 had DIC, his platelets dropped, and the resident passed away. He stated he usually investigates the reason if a resident passes away because he wants to know what happened. A telephone interview was conducted on [DATE] at 2:40 p.m. with the previous Nursing Home Administrator. She stated she was the Administrator at the facility at the time of the incident and completed the investigation for Resident #404. She stated the investigation was started due to a social media post related to Resident #404. She stated she completed investigation through chart review and staff interviews. She stated based on the chart review and staff interviews; the complaint was not substantiated. She stated she was completing two other investigations at the same time as Resident #404 and was unable to provide the location of the complete/full investigation. She reported the current staff have spoken with her and they are unable to locate all my notes. A review of the facility policy titled Abuse, Neglect, Exploitation & Misappropriation, revised on [DATE], revealed the following: Policy: It is inherent in the nature and dignity of each resident that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse. Employees of the center are charged with a continuing obligation to treat residents, so they are free from abuse, neglect, mistreatment and/or misappropriation of property. No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and/or misappropriation of property against any resident. Violation of this standard will subject employees to disciplinary action, including dismissal, provided herein. [.] Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include but are not limited to: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Failure to provide adequate nutrition and fluids. -Failure to take precautionary measures to protect the health and safety of the resident. -Intentional lack of attention to physical needs including, but not limited to, toileting and bathing. Failure to provide services that result in harm to the resident, such as not turning a bedfast resident or leaving a resident in a soiled bed. -Failure or refusal to provide a service for the purpose of punishing or disciplining a resident, unless withholding of a service is being used as part of a documented integrated behavioral management program. -Failure to notify a resident's legal representative in the event of a significant change in the resident's physical, mental or emotional condition that a prudent person would recognize. -Failure to notify a resident's legal representative in the event of an incident involving the resident, such as failure to report a fall or conflict between residents that result in injury or possible injury. -Failure to report observed or suspected abuse, neglect or misappropriation of resident property to the proper authorities. -Failure to adequately supervise a resident known to wander from the facility without the staff knowledge. Note: Such things as failure to comb a resident's hair on occasion would not necessarily constitute a reportable incidence of neglect. However, continued omission in providing daily care and/or failure to address and resolve the omission could constitute neglect. [.] Procedure: [.] Non-action, which results in emotional, psychological, or physical injury, is viewed in the same manner as that caused by improper or excessive action. All actions in which employees engage with residents must have the legitimate goal, the healthful, proper, and humane care and treatment of the resident. [.] 5. Investigation The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A Social Service representative may be offered in the role of resident advocate during any questioning of or interviewing of residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Investigations will be accomplished in the following manner: [.] Investigation: -The Abuse Coordinator and/or Director of Nursing shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39249 Based on interviews and record reviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice related to 1) a failure to communicate a significant change of condition to other licensed nurses and the physician, resulting in a delay of treatment for one resident (#404) out of seven residents sampled; 2) a failure to implement physician orders related to vital signs monitoring for one resident (#94) out of seven residents sampled and, 3) a failure to recognize and respond to a change in condition related to hypotension for one resident (#401) out of seven residents sampled. Resident #404 experienced a change of condition secondary to bleeding from four skin wounds on his arms and legs, which began on [DATE] at 1:00 p.m. The bleeding required four dressing changes to the upper extremities and two dressing changes to the lower extremities due to bleeding through the dressings over the course of 17 hours. On [DATE] at 7:25 a.m. Resident #404 was transferred to the hospital and subsequently died from widespread sepsis and bleeding caused by DIC (disseminated intravascular anticoagulation [a rare but serious condition that causes abnormal blood clotting throughout the body's blood vessels]). The resident was not provided professional standards of care and services to benefit from earlier assessment and treatment from a higher level of care. This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and or death to Resident #404 and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to a D after verification of removal of immediacy of harm. Findings included: 1. On [DATE] at 4:15 p.m. an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) to review a reportable incident for Resident #404. The DON stated she was familiar with Resident #404, and she could speak to the investigation conducted at the time of the incident. The DON stated a family member complaint was received on social media. The DON stated they investigated and did not find any problem with the care. The DON stated Resident #404 was not compliant with care and had displaced a wound vac. She stated Resident #404 was in and out of the hospital and the last time he was sent to the hospital he passed away. The DON stated Resident #404 was sent to the hospital due to bleeding, and he had saturated the dressings on his arms. The DON stated the resident was on Eliquis as a blood thinner, and the family member complained that the resident was not sent to the hospital soon enough. A review of the medical record revealed Resident #404 was admitted on [DATE] with diagnoses, including but not limited to, cerebral infarction due to thrombosis of right middle cerebral artery, chronic pancreatitis, unspecified open wounds to left ankle, neck, right lower leg, right thigh, left hip, left lower leg, lower back, and pelvis without penetration to retroperitoneum, unspecified atrial fibrillation, gastrostomy status, unspecified gastrointestinal hemorrhage, unspecified anemia, and unspecified coagulation defect. A review of the Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #404 had a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Order Summary Report for Resident #404 revealed the following: [DATE] Full Code. [DATE] Labs: CBC (complete blood count), CMP (comprehensive metabolic profile) one time only for admission labs for one day. [DATE] Aspirin 81 tablet chewable 81 MG (milligrams) give one tablet by mouth one time a day for DVT (deep vein thrombosis) prevention. [DATE] Eliquis oral tablet 5 MG (Apixaban) give one tablet by mouth two times a day for coagulopathy. [DATE] Furosemide oral tablet 80 MG give one tablet by mouth two times a day for pleural effusion. [DATE] Left hip cleanse with normal saline, silver nitrate dampened gauze, and place border dressing every day shift every Tuesday and Friday for wound. [DATE] Left lateral ankle change wound vac every Tuesday and Friday, apply black granulofoam, set section to 125 MMHG (millimeters/mercury) every day shift every Tuesday and Friday for wound. [DATE] Mid thoracic back cleanse with normal saline, xeroform, and place border dressing every day shift for wound. [DATE] Right heel cleanse with normal saline, apply skin prep, leave open to air every day shift every other day for DTI (deep tissue injury). [DATE] Left lateral ankle change wound vac, apply black granulofoam, set suction to 125 MMHG one time only for wound care for one day. [DATE] Right heel cleanse with normal saline, apply skin prep, leave open to air every night shift every other day to DTI. [DATE] Mid thoracic back cleanse with normal saline, xeroform, and place border dressing every night shift for wound. [DATE] Left ischium cleanse with normal saline, apply medihoney, then cover with mepilex every day shift every other day for wound care. [DATE] Left lateral ankle and mid back change wound vac every Monday and Thursday, apply black granulofoam, set suction to 125 MMHG, connect with Y-tubing every day shift every Monday and Thursday for wound. [DATE] Cleanse skin tear to left elbow apply TAO (triple antibiotic ointment) and DSD (dry sterile dressing) until healed then discontinue every night shift for skin tear care. [DATE] Cleanse skin tear to upper leg apply TAO and DSD until healed then discontinue every night shift for skin tear care. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] Zofran oral tablet 4 MG (Ondansetron) give one table by mouth every six hours as needed for nausea/vomiting. [DATE] CBC, CMP one time only for bleeding for one day. [DATE] Send to ER (emergency room) for evaluation one time only for bleeding for one day. A review of the Comprehensive Care Plan, initiated on [DATE], for Resident #404 revealed the following: Focus: The resident is on anticoagulant/anti-platelet therapy related to atrial fibrillation and CVA (cardiovascular accident). Revision [DATE]. Goal: The resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date. Interventions: Administer anticoagulant medications as ordered by physician. Monitor for side effects and effectiveness every shift. Daily skin inspection. Report abnormalities to the nurse. Monitor/document/report as needed adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Focus: The resident has a skin tear to left elbow and left leg. Initiated on [DATE]. Goal: The resident's skin tear will show signs of healing by review date. Interventions: Monitor/document location, size, and treatment of skin tear. Report abnormalities. A review of the Progress Notes for Resident #404 revealed the following: -[DATE] 10:17 a.m. Physician progress note: Patient is seen today for follow-up visit. It was reported by staff that he had a fall last night and hit his head. He was sitting on the side of the bed and was trying to position himself back to lying down when he fell over. He did not ask for help or use call light. Patient states he was having hallucinations and confused after he hit his head. The incident was not reported until this morning. Patient is on Eliquis and Aspirin, so he was sent out to the ER for a CT (computed tomography scan) of the head. He did receive multiple skin tears on his arm and leg. He also has a bruise/redness on his face. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-[DATE] 10:50 a.m. Nursing progress note: Resident heard calling out, resident observed on side of bed holding onto bed on right side and bedside table to the left side. Resident was in between. Resident assisted back to bed and care provided. ROM [range of motion] WNL [within normal limits]. No s/s [signs/symptoms] of acute distress. Routine pain med given, and wound care provided to skin tears. -[DATE] 7:51 a.m. Nursing progress note: Patient observed to have dislodged/saturated dressing to LUE [left upper extremity] at start of shift, changed patients dressing per physicians order. after receiving PM [evening] medications dressings observed to be saturated again, cleaned wounds to LUE and R [right] forearm and applied ABD [abdominal] pads with krelix [sig] and ace wrap on top to apply pressure. Patient c/o [complains of] nausea and prior emesis,, administer PRN [as needed] Zofran to good effect. Notified physician at 2130 of patients saturation of dressings and treatment applied. Physician ordered for dressing to stay in place until am then to be removed for assessment and CBC to be drawn on [DATE]. At approximately 0630 dressing was removed with some saturation through the ace wrap with the gauze noted to be heavily saturated. Notified physician and received order to send to ER to evaluation and to control bleeding .Called 911 at 0714 upon entering room at approximately 0725 with EMS [emergency medical services] patient had emesis in container dark brown with some red noted approximately 100 ML [milliliter] in container, Resident left facility with EMS at approximately 0730 via stretcher, notified patients emergency contact A review of the Treatment Administration Record (TAR), dated [DATE]-[DATE], for Resident #404 revealed the following: Cleanse Skin tear to left elbow apply TAO and DSD until healed every night shift for skin tear documented as completed once on [DATE]. Cleanse skin tear to left upper leg apply TAO and DSD until healed every night shift for skin tear care documented as completed once on [DATE]. A review of the Medication Administration Record (MAR), dated [DATE]-[DATE], for Resident #404 revealed the following: Aspirin 81 MG give one tablet by mouth one time a day for DVT prevention documented as administered on [DATE] at 9:00 a.m. Eliquis oral tablet 5 MG give one tablet by mouth two times a day for coagulopathy documented as administered on [DATE] at 9:00 a.m. and 5:00 p.m. Furosemide oral tablet 80 MG give one tablet by mouth two times a day for pleural effusion documented as administered on [DATE] at 9:00 a.m. and 5:00 p.m. Zofran oral tablet 4 MG give one tablet by mouth every six hours as needed for N/V not documented as given on [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:49 p.m., a telephone interview was conducted with a Family Member (FM) of Resident #404. The FM stated Resident #404 transferred from the hospital to the facility in March and seemed to be getting better. The FM stated the resident went to the hospital for an abscessed tooth. The FM stated she went to see Resident #404 every day and stayed with him all day long at the facility. The FM stated she would have a good friend drive her there and pick her up. The FM stated on [DATE] she escorted the resident to the courtyard to smoke and when she put her hand on the handle of the wheelchair she picked up her hand to find it full of blood. She stated that was a few days before Resident #404 died . The FM stated the resident was bleeding from his leg, arm, and shoulder area. The FM stated the shoulder was sopping with blood, and she took the dressing off and went in to the facility to get someone to put something over the area. The FM stated the nurse started yelling at Resident #404 for taking off the dressing. She stated then someone came in and put a dressing on the area. The FM stated she had seen the Resident #404 throwing up blood during the day in his urinal. The FM stated she went to the nursing station and asked the nurse to please call EMS and get an ambulance to come. The FM stated when she told the nurse Resident #404 was bleeding out the staff all started laughing and said they wouldn't let him bleed out. She stated the nurse never went down to check on the resident at all. She stated her friend was with Resident #404 in the room and saw him take two sips of water and throw up blood in the urinal. The FM stated it was close to 7pm [DATE], the day before he went to the hospital. The FM stated the next morning she got a call from a man who said he sent Resident #404 to the hospital because he was bleeding out. The FM stated when she got to the hospital, Resident #404 was on life support, and they had to keep giving him blood. The FM stated the nurse never left the nurse's station the night she was there to go in and check on Resident #404 from the time she asked for the resident to go to the hospital until the time she left the facility. On [DATE] at 07:06 p.m., an interview was conducted with Staff A, Licensed Practical Nurse (LPN). She stated she remembers the resident, and mentioned the mother visited daily. She confirmed she was the assigned nurse to Resident #404 on [DATE] day shift a.m. to 7 p.m. She stated she remembered he was bleeding while in the courtyard with his FM. She stated the resident told her he took his bandages off so he could let them breathe. She stated after he returned inside the facility, she applied dressings to both upper extremities. Staff A stated she informed the oncoming nurse for the night shift. She stated during her shift she changed the dressings twice because of visible blood and saturation through the dressings. She stated she used a kerlix roll dressing. She stated she thought she changed it around ,d+[DATE] p.m., then prior to shift change at 7 p.m. it needed to be changed again. She stated the FM was on the patio with the resident while he was smoking. Staff A stated she let the night nurse know Resident #404 was bleeding from his arms. She stated she reported she had re-wrapped the arms. She stated it was unusual to have to change the dressings twice. She stated she did not call the doctor. She stated Resident #404 had quite a few wounds and she had changed one on his leg and his wound vac. She stated the wound vac had quite a bit of drainage and had an odor to it. She stated she did not recall any nausea or vomiting. She stated she really was not thinking about the resident being on blood thinners. She stated she did not make any notes, do a change of status, or notify the doctor of the need to change dressings due to bleeding. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 7:29 p.m., an interview was conducted with Staff O, RN (Registered Nurse, Unit Manager). She stated Resident #404 was admitted from the hospital but unable to recall the specifics of his admission. She stated Resident #404 had a lot of different wounds. She said his FM visited almost every day. She stated she knew the resident was sent out for a bleed. She stated she was told there were allegations of neglect because of an on-line review. She stated she did not participate in the investigation and stated abuse investigations are generally completed by the DON/NHA. She stated the nurses are expected to document changes in condition and notify the physician in the medical record. She stated if a resident's family asked for them to be sent to the hospital the nurses are supposed to do so and let the doctor know what is happening. On [DATE] at 9:22 a.m., an interview was conducted with Staff P, LPN (Licensed Practical Nurse). He stated he knew Resident #404 had falls, skin tears and could be grumpy, but did not recall Resident #404's plan of care. He stated Resident #404 had dressings all over, had a lot of skin tears, and a wound vac to his sacrum. The nurse stated in report he was told while the FM visited with the resident in the courtyard, the resident was picking at his dressings, and (Staff A) told him she had just changed his dressings. He stated he did not recall (Staff A) saying that was the second time she had to change the dressings. He stated, After report around 7:45 p.m., I saw the dressing on his left arm was not really on but the mepilex dressing had some bleeding on it. I'm not sure who transferred the resident back to bed but there was some blood smeared on the wall by his bed. I changed the dressings to his arms and legs all at once and cleaned the blood off the wall. When giving him his night meds [9:00 p.m.], I saw the dressings on his upper arms were saturated and the current dressing was not appropriate for the amount of bleeding. The dressing was red in color. The dressing to his legs were not saturated. I changed the dressings on his legs. I applied ABD, Kerlix and pressure dressings to his arms. I changed all the dressings [legs and arms] to have a timeline of how much he was bleeding. I used gauze pads on his legs, because they were absorbent and easy to see changes. I notified the MD about 9:30 p.m. and he said to leave the dressings in place and draw a CBC [[DATE]] and leave those dressings in place until the morning and then to remove them for assessment. I rounded on him to make sure there was no visible bleeding throughout the shift. The nurse stated he did not remove the ace wrap during the night to keep pressure on the arms. He stated about 6:00 a.m. he removed the ace wrap and saw the wound had bled through to the ace and Resident #404 told him he had vomited on the prior shift. Staff P, LPN stated the previous nurse had not reported the resident had vomited. On [DATE] at 11:02 a.m. an interview was conducted with the Primary Care Physician (PCP) for Resident #404. The PCP stated he did not recall specifically being notified about Resident #404 on [DATE]. He stated if he was notified for the first time that a resident was having a bleeding episode he would have told them to monitor and apply a pressure dressing. He stated he did not recall being contacted during the day shift about any bleeding the resident was having. He stated if he was told of previous episodes of bleeding and multiple changes of dressings he would have told them to send the resident out to be evaluated. He stated it was not ideal that the nurses did not notify him of multiple dressing changes, and he would have expected them to report any vomiting of blood as well. The PCP stated if he had been aware of the bleeding wounds and vomiting blood, he would have sent him out. He stated what he was told was not the same as what occurred. He stated his partner admitted Resident #404 to the hospital and the resident died of sepsis with complications. He stated the resident had fungus in the blood cultures. He stated he reviewed the chart in the hospital and Resident #404 had DIC, his platelets dropped, and the resident passed away. He stated he usually investigates the reason if a resident passes away because he wants to know what happened. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Disseminated intravascular coagulation, or DIC, is a complicated condition that can occur when someone has severe sepsis or septic shock. Both blood clotting and difficulty with clotting may occur, causing a vicious cycle. Small blood clots can develop throughout your bloodstream, especially in the microscopic blood vessels called capillaries. This blocks the blood flow to many parts of your body, including your limbs and your organs. Blood is then not able to bring oxygen and nutrients to the tissues. On the reverse side of the cycle, DIC can increase bleeding. The body uses up so many of the blood clotting proteins for the multiple blood clots in the blood vessels that there are not enough left to clot the blood elsewhere. Several medical conditions can cause DIC, including sepsis. DIC affects about 35% of patients who have sepsis. Sepsis, which was often called blood poisoning, is the body's life-threatening response to infection. Like strokes or heart attacks, sepsis is a medical emergency that requires rapid diagnosis and treatment. (Sepsis Alliance, Sepsis and Disseminated Intravascular Coagulation. 2023. https://www.sepsis.org/sepsisand?disseminated-intravascular-coagulation-dic/) On [DATE] at 11:23 a.m. an interview was conducted with Staff Q, CNA (Certified Nursing Assistant). The CNA stated she remembered Resident #404 and she provided care for him often. She stated a FM came to see the resident almost every day. She stated she remembered the resident vomiting a lot and bleeding from the dressings. She stated the resident always asked for pain medications. She stated she would clean up the resident and empty his urinal because he would vomit in it. She stated she always reported vomiting to the nurse, but she did not document that in the medical record because there is no place for them to do that, she stated she left that for the nurse to do. She stated she did recall him having bleeding and vomiting before he went to the hospital, and she told the nurse, but she does not recall if the nurse went in to check on the resident. She described the bleeding and vomiting as dark brown. She stated the only reasons Resident #404 would call was to be changed, have his dressings changed, vomiting, or taking pain pills. On [DATE] at 8:07 p.m. an interview was conducted with a Family Friend (FF), who would transport the FM to and from the facility and visit with Resident #404. The FF stated he would take the FM to visit Resident #404 nearly every day and he was present at the facility on [DATE] the weekend before Resident #404 passed away. He stated when he saw Resident #404 on the evening of [DATE] the resident was coherent and he had bruises all over, blood on his sheets, and blood on the walls in his room. He stated he and the FM where in the room with Resident #404 for about an hour and a half. The FF stated he got the resident a glass of water, but the resident was not able to keep it down and he was throwing up blood. He stated they informed the nurses. The FF stated if the resident took a drink of water he would throw up blood in less than a minute and it was dark red. The FF stated Resident #404 asked him to take him to the hospital to avoid getting charged any money and he told him he couldn't take him because of his medical needs. The FF stated he went to the hallway and told a lady nurse that Resident #404 was throwing up blood and she was just like oh ok. He stated the nurse did not go to the room to see what was going on. He stated he has really tried to block the whole incident out of his memory. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility policy titled Anticoagulant Therapy, revised on [DATE], revealed the following: Procedure: -Obtain physician's order for anticoagulant therapy and labs. -Alert lab -Initiate anticoagulant flow sheets or electronic equivalent -Post lab results on flow sheet or electronic equivalent, indicating date -Identify resident and explain therapy -Perform hand hygiene -Document the time, dose administration on MAR and anticoagulant flow sheet/ electronic equivalent -Monitor the resident for signs of bleeding. *Observe for hematoma development or excessive bleeding or bruising. *Test stool, urine, emesis for Guaiac/Hemoccult as ordered by physician. *Monitor labs per physician's order. *Use pressure-dressing PRN until bleeding stops. *Perform hand hygiene. *Document in the medical record. Note-Residents requiring Coumadin (Warfarin) administration should have lab work drawn as ordered by the physician to determine effectiveness of therapy and subsequent dosages. 2. A review of the medical record revealed Resident #94 was admitted to the facility with diagnoses including pulmonary fibrosis, unspecified, acute respiratory failure with hypoxia, acute respiratory failure hypercapnia, Chronic Obstructive Pulmonary Disease (COPD), unspecified, emphysema, unspecified, pneumoconiosis due to other dust containing silica, shortness of breath (SOB), obstructive sleep apnea, pneumothorax, unspecified. A review of Resident #94's admission Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition. A review of the Comprehensive Care Plan, dated [DATE], for Resident #94 revealed the following: Focus: The resident has emphysema/COPD r/t (related to) exposure to industrial pollutants. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Goals: Resident will be free of signs/symptoms of respiratory infections through review date. Interventions: Give aerosol or bronchodilators as ordered; Monitor/ document and side effect and effectiveness; Head of the bed elevated or out of bed upright in a chair during episodes of difficulty breathing; Monitor for difficulty breathing (dyspnea) on exertion; Remind resident not to push beyond endurance; Monitor for signs and symptoms of acute respiratory insufficiency: anxiety, confusion, restlessness, shortness of breath at rest, cyanosis, somnolence; Monitor/document/report as needed any signs/symptoms of respiratory infection. Focus: The resident has altered respiratory breathing status/difficulty breathing related to sleep apnea. Goals: The resident will have minimal risk of complications related to SOB. Interventions: Administer medication/puffers as ordered; Monitor for effectiveness and side effects; Monitor/document changes in orientation, increased restlessness, anxiety and air hunger; Monitor for signs/symptoms of respiratory distress and report to doctor as needed. A review of progress notes, dated [DATE] at 08:09:00, revealed a nursing progress note as follows: Certified nursing assistant (CNA) assigned to client called this writer to assess client. This writer observed client lying in semi-Fowlers position and oxygen continues at 3 liters per minute via nasal cannula unresponsive. This writer checked for pulse; no pulse noted. CPR [cardiopulmonary resuscitation] was initiated, and this writer called out to another nurse to call 911. CPR continued till EMS's [emergency medical services] arrived. CPR was terminated @0355. MD [medical doctor] and clients POA [power of attorney] was notified @0400 and new orders received to release body. A review of physician orders for Resident #94 revealed an order for vital signs every day shift. The order was to begin on [DATE], there was no end date listed. An order for full code with a start date of [DATE], and end date of [DATE] A review of the medical record revealed under the weights/ vital sign tab only pulse oximetry and respirations were recorded between [DATE] and [DATE]. An interview was conducted on [DATE] at 01:00 PM with the Director of Nursing (DON). She stated vital signs should be documented in the weight/vital signs tab, or in progress notes, and in nursing assessments. She stated the vital signs (V/S) may show up in the POC (point of care) if the CNA (Certified Nursing Assistant) puts them in. The DON stated the orders for the V/S are part of a batch order and should be followed by nursing. The DON confirmed there were no VS taken as ordered from [DATE] through [DATE]. A review of the code sheet, dated [DATE], revealed no vital signs were listed on the document. A review of the facility policy titled Physician Orders, revised on [DATE], revealed the following: Policy: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39249 Based on interviews and record reviews, the facility failed to ensure there were competent staff to provide nursing services in order to assure resident safety and well-being for three residents (#404, #94, and #401) out of seven residents sampled. Findings included: 1. A review of the medical record revealed Resident #404 was admitted on [DATE] with diagnoses, including but not limited to, cerebral infarction due to thrombosis of right middle cerebral artery, chronic pancreatitis, unspecified open wounds to left ankle, neck, right lower leg, right thigh, left hip, left lower leg, lower back, and pelvis without penetration to retroperitoneum, unspecified atrial fibrillation, gastrostomy status, unspecified gastrointestinal hemorrhage, unspecified anemia, and unspecified coagulation defect. A review of the Order Summary Report for Resident #404 revealed the following: [DATE] Full Code. [DATE] Labs: CBC (complete blood count), CMP (comprehensive metabolic profile) one time only for admission labs for one day. [DATE] Aspirin 81 tablet chewable 81 MG (milligrams) give one tablet by mouth one time a day for DVT (deep vein thrombosis) prevention. [DATE] Eliquis oral tablet 5 MG (Apixaban) give one tablet by mouth two times a day for coagulopathy. [DATE] Cleanse skin tear to left elbow apply TAO (triple antibiotic ointment) and DSD (dry sterile dressing) until healed then discontinue every night shift for skin tear care. [DATE] Cleanse skin tear to upper leg apply TAO and DSD until healed then discontinue every night shift for skin tear care. [DATE] Zofran oral tablet 4 MG (Ondansetron) give one table by mouth every six hours as needed for nausea/vomiting. [DATE] CBC, CMP one time only for bleeding for one day. [DATE] Send to ER (emergency room) for evaluation one time only for bleeding for one day. A review of the Comprehensive Care Plan, initiated on [DATE], for Resident #404 revealed the following: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus: The resident is on anticoagulant/anti-platelet therapy related to atrial fibrillation and CVA (cardiovascular accident). Revision [DATE]. Goal: The resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date. Interventions: Administer anticoagulant medications as ordered by physician. Monitor for side effects and effectiveness every shift. Daily skin inspection. Report abnormalities to the nurse. Monitor/document/report as needed adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Focus: The resident has a skin tear to left elbow and left leg. Initiated on [DATE]. Goal: The resident's skin tear will show signs of healing by review date. Interventions: Monitor/document location, size, and treatment of skin tear. Report abnormalities. A review of the Progress Notes for Resident #404 revealed the following: [DATE] 7:51 a.m. Nursing progress note: Patient observed to have dislodged/saturated dressing to LUE [left upper extremity] at start of shift, changed patients dressing per physicians order. after receiving PM [evening] medications dressings observed to be saturated again, cleaned wounds to LUE and R [right] forearm and applied ABD [abdominal] pads with krelix [sig] and ace wrap on top to apply pressure. Patient c/o [complains of] nausea and prior emesis,, administer PRN [as needed] Zofran to good effect. Notified physician at 2130 of patients saturation of dressings and treatment applied. Physician ordered for dressing to stay in place until am then to be removed for assessment and CBC to be drawn on [DATE]. At approximately 0630 dressing was removed with some saturation through the ace wrap with the gauze noted to be heavily saturated. Notified physician and received order to send to ER to evaluation and to control bleeding .Called 911 at 0714 upon entering room at approximately 0725 with EMS [emergency medical services] patient had emesis in container dark brown with some red noted approximately 100 ML [milliliter] in container, Resident left facility with EMS at approximately 0730 via stretcher, notified patients emergency contact A review of the Treatment Administration Record (TAR), dated [DATE]-[DATE], for Resident #404 revealed the following: Cleanse Skin tear to left elbow apply TAO and DSD until healed every night shift for skin tear documented as completed once on [DATE]. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cleanse skin tear to left upper leg apply TAO and DSD until healed every night shift for skin tear care documented as completed once on [DATE]. A review of the Medication Administration Record (MAR), dated [DATE]-[DATE], for Resident #404 revealed the following: Aspirin 81 MG give one tablet by mouth one time a day for DVT prevention documented as administered on [DATE] at 9:00 a.m. Eliquis oral tablet 5 MG give one tablet by mouth two times a day for coagulopathy documented as administered on [DATE] at 9:00 a.m. and 5:00 p.m. Zofran oral tablet 4 MG give one tablet by mouth every six hours as needed for N/V not documented as given on [DATE]. On [DATE] at 07:06 p.m., an interview was conducted with Staff A, Licensed Practical Nurse (LPN). She stated she remembers the resident, and mentioned the mother visited daily. She confirmed she was the assigned nurse to Resident #404 on [DATE] day shift a.m. to 7 p.m. She stated she remembered he was bleeding while in the courtyard with his FM. She stated the resident told her he took his bandages off so he could let them breathe. She stated after he returned inside the facility, she applied dressings to both upper extremities. Staff A stated she informed the oncoming nurse for the night shift. She stated during her shift she changed the dressings twice because of visible blood and saturation through the dressings. She stated she used a kerlix roll dressing. She stated she thought she changed it around ,d+[DATE] p.m., then prior to shift change at 7 p.m. it needed to be changed again. She stated the FM was on the patio with the resident while he was smoking. Staff A stated she let the night nurse know Resident #404 was bleeding from his arms. She stated she reported she had re-wrapped the arms. She stated it was unusual to have to change the dressings twice. She stated she did not call the doctor. She stated Resident #404 had quite a few wounds and she had changed one on his leg and his wound vac. She stated the wound vac had quite a bit of drainage and had an odor to it. She stated she did not recall any nausea or vomiting. She stated she really was not thinking about the resident being on blood thinners. She stated she did not make any notes, do a change of status, or notify the doctor of the need to change dressings due to bleeding. On [DATE] at 7:29 p.m., an interview was conducted with Staff O, RN (Registered Nurse, Unit Manager). She stated Resident #404 was admitted from the hospital but unable to recall the specifics of his admission. She stated Resident #404 had a lot of different wounds. She said his FM visited almost every day. She stated she knew the resident was sent out for a bleed. She stated she was told there were allegations of neglect because of an on-line review. She stated she did not participate in the investigation and stated abuse investigations are generally completed by the DON/NHA. She stated the nurses are expected to document changes in condition and notify the physician in the medical record. She stated if a resident's family asked for them to be sent to the hospital the nurses are supposed to do so and let the doctor know what is happening. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:22 a.m., an interview was conducted with Staff P, LPN (Licensed Practical Nurse). He stated he knew Resident #404 had falls, skin tears and could be grumpy, but did not recall Resident #404's plan of care. He stated Resident #404 had dressings all over, had a lot of skin tears, and a wound vac to his sacrum. The nurse stated in report he was told while the FM visited with the resident in the courtyard, the resident was picking at his dressings, and (Staff A) told him she had just changed his dressings. He stated he did not recall (Staff A) saying that was the second time she had to change the dressings. He stated, After report around 7:45 p.m., I saw the dressing on his left arm was not really on but the mepilex dressing had some bleeding on it. I'm not sure who transferred the resident back to bed but there was some blood smeared on the wall by his bed. I changed the dressings to his arms and legs all at once and cleaned the blood off the wall. When giving him his night meds [9:00 p.m.], I saw the dressings on his upper arms were saturated and the current dressing was not appropriate for the amount of bleeding. The dressing was red in color. The dressing to his legs were not saturated. I changed the dressings on his legs. I applied ABD, Kerlix and pressure dressings to his arms. I changed all the dressings [legs and arms] to have a timeline of how much he was bleeding. I used gauze pads on his legs, because they were absorbent and easy to see changes. I notified the MD about 9:30 p.m. and he said to leave the dressings in place and draw a CBC [[DATE]] and leave those dressings in place until the morning and then to remove them for assessment. I rounded on him to make sure there was no visible bleeding throughout the shift. The nurse stated he did not remove the ace wrap during the night to keep pressure on the arms. He stated about 6:00 a.m. he removed the ace wrap and saw the wound had bled through to the ace and Resident #404 told him he had vomited on the prior shift. Staff P, LPN stated the previous nurse had not reported the resident had vomited. On [DATE] at 11:23 a.m. an interview was conducted with Staff Q, CNA (Certified Nursing Assistant). The CNA stated she remembered Resident #404 and she provided care for him often. She stated a FM came to see the resident almost every day. She stated she remembered the resident vomiting a lot and bleeding from the dressings. She stated the resident always asked for pain medications. She stated she would clean up the resident and empty his urinal because he would vomit in it. She stated she always reported vomiting to the nurse, but she did not document that in the medical record because there is no place for them to do that, she stated she left that for the nurse to do. She stated she did recall him having bleeding and vomiting before he went to the hospital, and she told the nurse, but she does not recall if the nurse went in to check on the resident. She described the bleeding and vomiting as dark brown. She stated the only reasons Resident #404 would call was to be changed, have his dressings changed, vomiting, or taking pain pills. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:02 a.m. an interview was conducted with the Primary Care Physician (PCP) for Resident #404. The PCP stated he did not recall specifically being notified about Resident #404 on [DATE]. He stated if he was notified for the first time that a resident was having a bleeding episode he would have told them to monitor and apply a pressure dressing. He stated he did not recall being contacted during the day shift about any bleeding the resident was having. He stated if he was told of previous episodes of bleeding and multiple changes of dressings he would have told them to send the resident out to be evaluated. He stated it was not ideal that the nurses did not notify him of multiple dressing changes, and he would have expected them to report any vomiting of blood as well. The PCP stated if he had been aware of the bleeding wounds and vomiting blood, he would have sent him out. He stated what he was told was not the same as what occurred. He stated his partner admitted Resident #404 to the hospital and the resident died of sepsis with complications. He stated the resident had fungus in the blood cultures. He stated he reviewed the chart in the hospital and Resident #404 had DIC, his platelets dropped, and the resident passed away. He stated he usually investigates the reason if a resident passes away because he wants to know what happened. A review of the facility policy titled Anticoagulant Therapy, revised on [DATE], revealed the following: Procedure: -Obtain physician's order for anticoagulant therapy and labs. -Alert lab -Initiate anticoagulant flow sheets or electronic equivalent -Post lab results on flow sheet or electronic equivalent, indicating date -Identify resident and explain therapy -Perform hand hygiene -Document the time, dose administration on MAR and anticoagulant flow sheet/ electronic equivalent -Monitor the resident for signs of bleeding. *Observe for hematoma development or excessive bleeding or bruising. *Test stool, urine, emesis for Guaiac/Hemoccult as ordered by physician. *Monitor labs per physician's order. *Use pressure-dressing PRN until bleeding stops. *Perform hand hygiene. *Document in the medical record. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Note-Residents requiring Coumadin (Warfarin) administration should have lab work drawn as ordered by the physician to determine effectiveness of therapy and subsequent dosages. 2. A review of the medical record revealed Resident #94 was admitted to the facility with diagnoses including pulmonary fibrosis, unspecified, acute respiratory failure with hypoxia, acute respiratory failure hypercapnia, Chronic Obstructive Pulmonary Disease (COPD), unspecified, emphysema, unspecified, pneumoconiosis due to other dust containing silica, shortness of breath (SOB), obstructive sleep apnea, pneumothorax, unspecified. A review of the Comprehensive Care Plan, dated [DATE], for Resident #404 revealed the following: Focus: The resident has emphysema/COPD r/t exposure to industrial pollutants. Goals: Resident will be free of signs/symptoms of respiratory infections through review date. Interventions: Give aerosol or bronchodilators as ordered; Monitor/ document and side effect and effectiveness; Head of the bed elevated or out of bed upright in a chair during episodes of difficulty breathing; Monitor for difficulty breathing (dyspnea) on exertion; Remind resident not to push beyond endurance; Monitor for signs and symptoms of acute respiratory insufficiency: anxiety, confusion, restlessness, shortness of breath at rest, cyanosis, somnolence; Monitor/document/report as needed any signs/symptoms of respiratory infection. Focus: The resident has altered respiratory breathing status/difficulty breathing related to sleep apnea. Goals: The resident will have minimal risk of complications related to SOB. Interventions: Administer medication/puffers as ordered; Monitor for effectiveness and side effects;; Monitor/document changes in orientation, increased restlessness, anxiety and air hunger; Monitor for signs/symptoms of respiratory distress and report to doctor as needed. A review of progress notes, dated [DATE] at 08:09:00, revealed a nursing progress note as follows: Certified nursing assistant (CNA) assigned to client called this writer to assess client. This writer observed client lying in semi-Fowlers position and oxygen continues at 3 liters per minute via nasal cannula unresponsive. This writer checked for pulse; no pulse noted. CPR [cardiopulmonary resuscitation] was initiated, and this writer called out to another nurse to call 911. CPR continued till EMS's [emergency medical services] arrived. CPR was terminated @0355. MD [medical doctor] and clients POA [power of attorney] was notified @0400 and new orders received to release body. A review of physician orders for Resident #94 revealed an order for vital signs every day shift. The order was to begin on [DATE], there was no end date listed. An order for full code with a start date of [DATE], and end date of [DATE] A review of the medical record revealed under the weights/ vital sign tab only pulse oximetry and respirations were recorded between [DATE] and [DATE]. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on [DATE] at 01:00 PM with the Director of Nursing (DON). She stated vital signs should be documented in the weight/vital signs tab, or in progress notes, and in nursing assessments. She stated the vital signs (V/S) may show up in the POC (point of care) if the CNA (Certified Nursing Assistant) puts them in. The DON stated the orders for the V/S are part of a batch order and should be followed by nursing. The DON confirmed there were no VS taken as ordered from [DATE] through [DATE]. A review of the facility policy titled Physician Orders, revised on [DATE], revealed the following: Policy: The center will ensure that Physician orders are appropriately and timely documented in the medical record. Procedure: ADMISSION ORDERS: Information received from the referring facility or agency to be reviewed, verified with the physician and transcribed to the electronic medical record. The attending physician will review and confirm orders. Confirmation of admission orders requires that the physician sign and date the order during, or as soon as practicable after it is provided, to maintain an accurate medical record. ROUTINE ORDERS: A Nurse may accept a telephone order from the Physician, Physician Assistant or Nurse Practitioner (as permitted by state law). The order will be repeated by the physician, PA or ARNP for his/her verbal confirmation. The other is transcribed to all appropriate areas of the electronic health record (eMAR/eTAR). For pharmacy orders, the nurse will notify the pharmacy per pharmacy policy by telephoning, faxing or completing the order electronically. The ordering physician or physician extender will review and confirm orders. Confirmation of routine orders requires that the physician sign and date the order as soon as practicable after it is provided to maintain an accurate medical record. 3. Resident #401 was admitted to the facility on [DATE] with diagnoses including unspecified peritonitis, essential hypertension, Type 2 Diabetes Mellitus without complications, unspecified chronic kidney disease stage 3, acute appendicitis with localized peritonitis without perforation or gangrene, cognitive communication deficit, unsteadiness on feet, and need for personal assistance with personal care. Resident #401 was discharged to a higher level of care [hospital] on [DATE]. A review of the physician orders for Resident #401 revealed the following: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Lisinopril -Hydrochlorothiazide oral tablet ,d+[DATE] milligrams(mg) to give one tablet by mouth one time a day for hypertension. -Carvedilol oral tablet 12.5 mg to give one tablet by mouth two times a day for hypertension. -Monitor vital signs every shift. On [DATE] during the day shift, Resident #401's blood pressure was documented as ,d+[DATE] mmHg (millimeters of Mercury), with a second blood pressure documented on the afternoon shift as ,d+[DATE] mmHg. A review of the Medication Administration Record (MAR), [DATE], showed Lisinopril-Hydrochlorothiazide and the Carvedilol were administered as scheduled at 09:00 a.m., and Carvedilol was administered as scheduled at 5:00 p.m. A review of the Change of Condition document, dated [DATE] at 6:45 p.m., showed the following: -altered level of consciousness -blood pressure of ,d+[DATE] mmHg -summary: This nurse entered pt. room and observed pt. not behaving in her usual self and difficult to arouse. Vital signs taken B/P ,d+[DATE], P-88, temperature 97.7, unable to take O2 sat at this moment. The physician was notified at 6:45 p.m. with instructions to call 911. Family member notified on [DATE] at 6:51 p. m. A review of physical therapy notes, dated [DATE] at 4:43 p.m., showed Resident #401 participating in therapy. patient limited with minimal active muscle engagement with bilateral lower extremity therapeutic exercises with maximal performance cuing, assist to complete each. Blood pressure reading have been in a lower range per nursing, and they are aware of functional decline since evaluation. A review of occupational therapy notes, dated [DATE] at 2:59 p.m., showed client required maximal assist for all bed mobility. She required Hoyer lift into the chair. Attempted to get patient to hold head up and follow verbal directive to sit, lean forward, however she required total assist. A review of speech therapy notes, dated [DATE] at 5:38 p.m., showed patient required moderate to maximal cues to follow simple commands and answer simple questions. Patient noted to be lethargic, which nursing noted. Patient was able to indicate personal information independently however response time was increased. A review of Resident #401's progress note, dated [DATE] at 2:39 p.m., showed the following: resident up for PT, resident BP 110 / 67 before PT interaction. [Staff R, Speech Therapist], to give resident fluids previous to PT to ensure swallowing capabilities intact, [Staff S, Physical Therapist]returned patient, resident BP 117 / 72 per [Staff S], PT reported resident did well in PT, report given to oncoming nurse to ensure residents stay hydrated and eats dinner, also advised oncoming nurse to check BP to ensure patient is not hypotensive. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy titled Notification of Change in Condition, revised on [DATE], revealed the following: Policy: The Center to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is a change in the status or condition. Procedure: -The nurse to notify the attending physician and Resident Representative when there is a(n): *Accidents *Significant change in the patient/resident's physical, mental, or psychosocial status *Need to alter treatment significantly -New treatment -Discontinuation of a current treatment due to but not limited to: *Adverse consequences *Acute condition *Exacerbation of a chronic condition *A transfer or discharge of the Patient/Resident from the Center *Patient/Resident consecutively refuses medication and/or treatment (i.e. two or more times) *Patient/Resident is discharged without proper medical authority -In the event of an emergency situation, 911 to be called and the attending physician and the Resident Representative to be notified as soon as possible. -The nurse to complete an evaluation of the Patient/Resident. Document evaluation in the medical record. -The nurse will contact the physician. In the event that the attending physician does not respond in a reasonable amount of time, the Medical Director may be contacted. -If the Medical Director does not respond, call 911 and document in the medical record. -Notify the patient/resident and the resident representative of the change in condition. Document notification in the medical record. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Document resident/patient change in condition on 24 hour report -Complete SBAR as indicated A review of the facility policy titled Nursing Documentation Guidelines, undated, revealed the following: POLICY: Pertinent information should be documented in the individual's record in an accurate, timely, and legible manner. Definitions: Individual's Record: A permanent legal document that provides a comprehensive account of information about the individual's health care status. PROCEDURE: GENERAL GUIDELINES When to Chart 1. Record resident's condition, nursing actions and individual responses as soon as possible after they occur. 2. Document medications and treatments at the time they are administered. What to Chart 1. Symptoms/Subjective Data 2. Your observations and/or Assessments 3. All injuries, illnesses and unusual health changes until they are resolved. There should be entries in the nursing notes on a regular basis until the problem is no longer present. When the problem is resolved, it should documented [sic]. 4. All contacts with the primary care prescriber. a. Document what information was relayed to the primary care prescriber. b. If the primary care prescriber sees or reviews an individual's specific health problem, document what occurred: -the chart was reviewed, -the individual was seen, or (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Palma Sola Bay	6305 Cortez Rd W Bradenton, FL 34210

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. All entries in nursing notes are attributed to the author of the note.