

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER Aspire at Palma Sola Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49227</p> <p>Based on observations, interviews, and record review the facility failed to ensure preferences were honored for one resident (#248) out of nine sampled residents.</p> <p>Findings Included:</p> <p>On 07/08/24 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.</p> <p>On 07/08/24 at 12:33 p.m. Resident #248 was observed upright in a geriatric chair with a family member assisting him with his meal.</p> <p>On 07/08/24 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.</p> <p>On 07/09/24 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</p> <p>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.</p> <p>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.</p> <p>A review of Resident #248's order summary report, dated 07/11/24 showed orders to include: full activity and may have restorative/ maintenance program as indicated.</p> <p>A review of Resident #248's active care plan, initiated 07/01/24, showed the resident had an actual fall with minor injury related to unsteady gait. The interventions include place resident in common areas, initiated 7/2/24.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/11/24 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.</p> <p>On 07/11/24 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.</p> <p>On 07/11/24 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.</p> <p>On 07/11/24 at 8:00 p.m. Resident #248 was observed with eyes closed and laying in a geriatric chair facing the nurses' station.</p> <p>On 07/12/24 at 08:15 a.m. Resident #248 was observed with eyes closed and laying in a geriatric chair facing the nurses' station.</p> <p>Review of facility's policy titled, Resident Rights, effective on 11/30/2024, showed:</p> <p>Policy</p> <ul style="list-style-type: none"> -1. Make residents and their legal representatives aware of residents' rights. -2. Ensure that residents' rights are known to staff.

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50836</p> <p>Based on observations, interviews, and record review, the facility failed to provide a comprehensive care plan related to the use of a sling for one resident (#18) out of 26 residents sampled.</p> <p>Findings included:</p> <p>On 07/08/24 at 01:07 PM, Resident #18 was observed in the common area of the secured unit during dining with a sling on the left arm that was bunched up by her elbow, not supporting any of her arm . The left hand appeared swollen, and the resident was resting the left arm down on the left thigh. An attempt to interview the resident revealed the resident was not interviewable.</p> <p>A review of the Admission Record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses to include dementia, Chronic Obstructive Pulmonary Disease (COPD), metabolic encephalopathy, and muscle weakness.</p> <p>A review of the care plan for Resident #18 revealed the following:</p> <p>Focus:</p> <p>The resident is at risk for changes in mood and behavior symptoms related to history of dementia and depression, history of panic attacks, aggression, exit seeking/wandering, elopement risk, removes sling. Date initiated: 05/30/2023; Revision on 05/10/2024</p> <p>Goal:</p> <p>The resident will maintain involvement in activities of daily living (ADL's) and daily routine through next review date. Date initiated: 05/30/2023; Revision on: 05/28/2024; Target date: 08/27/2024</p> <p>Interventions:</p> <p>Administer medications as ordered. Monitor/document for side effects an effectiveness. Date initiated: 05/30/2023</p> <p>Assist the resident, resident representative to identify strengths, positive coping skills and reinforce these. Date initiated: 05/30/2023</p> <p>Educate the resident/resident representative regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance. Date initiated: 05/30/2023</p> <p>Review of Resident #18 orders revealed; Apply sling to left arm as tolerated. Start date:02/06/2024</p> <p>On 07/08/24 at 03:05 PM an interview was conducted with Staff J, Certified Nursing Assistant. Staff J stated the resident has the sling on to keep her arm from swelling up. Staff J stated she does not know why her arm is swollen.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 07/09/24 at 04:34 PM revealed Resident #18 in the common area of the east wing memory unit ambulating with left arm sling bunched up around her elbow not supporting her arm. Her left arm was hanging down , near her waist.</p> <p>An observation on 07/10/24 at 09:30 AM revealed Resident #18 in common area of east wing memory unit, sitting with left arm sling bunched up to her elbow. Her left hand is swollen resting on her left thigh.</p> <p>An observation on 07/10/24 at 01:35 PM revealed Resident #18 with the left arm sling bunched up to her elbow, her left hand is swollen and resting on her left thigh.</p> <p>An observation on 07/10/24 at 03:43 PM revealed Resident #18 sitting in a chair on the east wing memory unit. Her sling was bunched up to her elbow. Her left hand was swollen and resting on her left thigh.</p> <p>An observation on 07/11/24 at 10:19 AM revealed Resident #18 with her left arm sling bunched up to her elbow. Her left hand was swollen and resting on her left thigh.</p> <p>An interview was conducted on 07/11/24 at 11:35 AM with Staff M,RN. Staff M stated usually the certified nursing assistant (CNA) puts Resident #18 left arm sling on, then the nurse checks it for proper placement. Staff M stated Resident #18 will move her arm down. Staff M stated they remind Resident #18 to position it properly. Staff M went on to state they usually have a compression sleeve on. Staff M stated therapy works with her currently. Staff M stated she does not think Resident #18 has treatment from therapy for edema. Staff M stated she will do range of motion (ROM) with Resident #18 occasionally. Staff M stated she does not think there is an order for compression sleeve. Staff M stated the staff apply it every day. Staff M stated compression sleeves are house stocked in the supply room. Staff M stated therapy does the initial assessment and provided the sling. Staff M stated she usually looks at the care plans. Staff M stated she does not go to care plan meetings because of her schedule. Staff M stated she would talk Director Of Nursing (DON)/ supervisor to initiate change if what they are doing is not effective. Staff M stated Resident #18 is on a diuretic for the edema.</p> <p>An interview was conducted on 07/11/24 at 12:09 PM the Director of Nursing (DON) stated she was unable to say why they would continue using the sling if it was not effective. The DON stated compression sleeves are generally ordered. The DON went on to state nursing can put in orders for compression sleeves. The DON stated the facility has not referred Resident #18 to a lymph specialist as far as she is aware. The DON stated they have discussed Resident #18 compliance, but the facility has not discussed any treatment changes,</p> <p>An interview on 07/11/24 at 03:33 PM Staff N,MDS Coordinator is aware of Resident #18 use of sling. Staff N stated Resident #18 left arm sling is in care plan under ADL, was not aware of compression sleeve use. Staff N stated she was aware of the left arm swelling. Staff N stated the facility has not discussed Resident #18's lymph edema. Staff N stated she reviews orders for care plans to initiate interventions and new areas of concern.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49497</p> <p>Based on observations, record review, and interviews, the facility failed to maintain and implement an effective infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, to prevent the development and transmission of communicable diseases and infections as evidenced by a lack of enhanced barrier precaution signage on doors of two residents (#81, #297) out of 20 residents on enhanced barrier precautions.</p> <p>Findings included:</p> <p>1. On 07/08/24 at 1:00pm observed Resident #297 IV (intravenous) port and dressing to right upper arm. Observed no enhanced barrier precaution sign on door and no storage bin outside of Resident #297 door with personal protective equipment (PPE) supplies.</p> <p>On 07/11/24 at 8:52 a.m. observed Resident #297 door with no enhanced barrier precaution signage or storage bin with PPE supplies located outside of door. Photo evidence obtained.</p> <p>Review of electronic medical record (EMR) for Resident #297 showed an admitted [DATE] with included diagnoses of encephalopathy, acute and subacute infective endocarditis, presence of artificial heart valve, arteriovenous malformation site unspecified, atherosclerosis of coronary artery bypass graft(s) without angina pectoris. Review of code status showed resident listed as a full code.</p> <p>Review of the Minimum Data Set (MDS) for Resident #297, dated 07/06/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment.</p> <p>A review of the 3008 form, dated 07/05/24, revealed:</p> <ul style="list-style-type: none"> - Comments section Daptomycin 300 mg IV daily. Duration 6-8 weeks. - Treatment devices, right PICC (peripherally inserted central catheter) inserted 06/21/24. <p>Review of the physician orders revealed:</p> <ul style="list-style-type: none"> - Return IV pump to pharmacy following IV therapy -Change dressing on admission or 24 hours after insertion and weekly thereafter and PRN -IVs: Type of access: midline. - IVs: Flush PICC or Midline with 10 mls of normal saline every shift and as needed. - Infectious disease appt 07/12/24 at 2:00 p.m. <p>A review of the care plan for Resident #297, dated 07/06/24, revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-A focus of The resident requires enhanced barrier precautions related to use of indwelling medical device IV PICC and is at risk for a CDC MDRO infection. Date initiated 07/08/2024. With intervention, Signage at designated area to alert staff and visitor of enhanced barrier precautions. Date initiated: 07/08/24.</p> <p>- A focus of The resident is on IV Medications r/t [related to] Endocarditis. Date Initiated: 07/06/24. With a goal of The resident will have not have [will not have] any complications related to IV Therapy through the review date. Date Initiated: 07/06/2024, Target Date: 10/04/2024.</p> <p>A review of the medical record for Resident #297 on 07/08/24 showed no physician order for enhanced barrier precaution.</p> <p>Review of the facility matrix revealed 20 residents are marked for enhanced barrier precautions. Resident #297 was not listed on facility matrix for enhanced barrier precautions.</p> <p>2. On 07/09/24 at 8:48 a.m., observed Resident #81's door with no enhanced barrier precaution signage on door.</p> <p>On 7/11/24 at 8:55 a.m. observed no enhance barrier precaution signage on Resident #81 door.</p> <p>Review of the medical record for Resident #81 showed an admission to facility on 03/02/24 with diagnoses that included osteomyelitis of vertebra, sacral and sacrococcygeal region, quadriplegia, methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere, unspecified psychosis not due to a substance or known physiological condition, major depressive disorder, malignant neoplasm of unspecified site of unspecified breast, colostomy status, presence of urogenital implants. Review of code status showed resident listed as do not resuscitate (DNR).</p> <p>A review of the Physician orders revealed:</p> <p>-03/02/24 PEG Tube, catheter and colostomy.</p> <p>-07/09/24 Enhance Barrier Precautions related to percutaneous endoscopic gastrostomy (PEG) Tube, Foley catheter and colostomy.</p> <p>A review of the care plan, dated 06/03/24, revealed:</p> <p>- A focus of enhanced barrier precautions related to use of indwelling medical device Foley Catheter, Peg tube, Colostomy and is at risk for a CDC MDRO infection. Date initiated 07/09/24. Interventions included Signage at designated area to alert staff and visitor of enhanced barrier precautions. Date initiated 07/09/24.</p> <p>- A focus of the resident requires enhanced barrier precautions related to chronic wounds requiring dressing/covering and is at risk for a CDC MDRO infection dated 07/09/24. With interventions that include education of need for enhanced barrier precaution provided to resident/family/caregivers. and signage at designated area to alert staff and visitor of enhanced barrier precautions. date initiated 07/09/24.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 07/11/24 at 1:47 p.m. with Staff E, Certified Nursing Assistant (CNA). She stated for any resident on infection precautions she is made aware by the signage on the door. She follows what the sign says, if it says gown and mask, I put on gown and mask before going in the room and take off and put in wastebasket before coming out to the hall.</p> <p>An interview was conducted on 07/11/24 at 1:51 p.m. with Staff D, Housekeeper. She stated, she knows when to wear PPE in a residents room by I follow signs on door and pointed to enhanced barrier precaution sign on a resident's door.</p> <p>An interview was conducted on 07/11/24 at 1:55 p.m. with Staff B, Physical Therapy Assistant. She stated she goes by the sign on resident's door and what is in a residents therapy evaluation to determine if a patient is on precautions before entering the room, to know what type of PPE is necessary.</p> <p>An interview was conducted on 07/11/24 at 2:10 p.m. with Staff A, Licensed Practical Nurse. She stated the residents should have a precaution sign on their door and plastic bin with proper PPE supplies. She stated they can look in medical record under resident medication administration record (MAR) and they should have a physician order for precautions. She stated enhanced precautions are for residents with Wound, intravenous therapy (IV), Foley etc. She stated PPE for enhanced precautions are gown, gloves and mask to be worn when entering room for staff providing direct care to resident. Hand washing for visitors or staff if no direct care is provided. She stated Staff C, Assistant Director of Nursing is the infection preventionist and is in charge of putting up and taking down all infection precaution signs. She stated if she is not available the nurse in charge of the resident would be responsible.</p> <p>An interview was conducted on 07/11/24 at 3:00 p.m. with Staff C, Infection Preventionist. She stated the three types of precautions followed are droplet, contact and enhanced barrier at the facility. She stated enhanced precautions require gloves, gowns and masks for staff who are providing direct patient care. Any resident with an indwelling medical device such as Foley's, IV's, PEG tubes, nephropathies, wound vac would be placed on enhanced precautions. She stated she would put signage on the door and get a bin of PPE when a confirmed resident is on any type of precaution. She stated currently they have bins ordered so they are being shared on the hallway till new ones arrive. She stated the resident would need to have an order in the EMR for a type of isolation or precaution. She stated if she is off work or resident admits over the weekend, the Director of Nursing (DON) or unit manager would be expected to hang signage and place PPE bin outside the door and ensure physician order is placed in the chart and relay information to hall nurse. She reviewed Resident #297's medical record and stated She has an order for enhanced precautions. It should have started when she was admitted on [DATE]. She stated, She has an IV so she automatically should be on enhanced precautions. She stated she would expect the DON or Unit Manager to complete PPE signage and bin for new resident as she is off when resident admitted . She stated, that's my mistake, the enhanced precautions sign should have been on the door (referring to Resident #297). She stated is should have been placed on day of admission because the resident was admitted with the IV.</p> <p>When questioned why Resident #81 did not have enhanced precaution signage on the door. She stated she should have been placed on enhanced precaution on 5/4/24 because of her Foley, peg tube and colostomy. She stated it was her mistake, I missed it. She stated the order in the chart for enhanced should have started on 05/04/24, the current order started on 07/09/24. She stated, We didn't catch it.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy for enhanced barrier precautions, dated August 2022, revealed the policy interpretation and implementation included:</p> <p>-#5 Enhanced barrier precautions (EBP) are indicated for resident with wounds and/or indwelling medical devices regardless of multidrug resistance organism (MDRO) colonization.</p> <p>-#10 Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required.</p>		