STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106029	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Lake Mary	710 North Sun Drive Lake Mary, FL 32746

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) Comprehensive Assessments were completed within the regulatory time frame for 5 of 8 residents reviewed for Resident Assessment, of a total sample of 40 residents, (#82, #88, #227, #228, and #233). Findings: 1. Resident #82 was admitted to the facility on [DATE]. Review of the resident's Annual MDS assessment with an Assessment Reference Date (ARD) of 4/13/24 revealed section Z0500 was signed by the Registered Nurse (RN) Assessment Coordinator and verified completion of the assessment on 5/01/24, 4 days late. 2. Resident #88 was admitted to the facility on [DATE]. Review of the resident's Significant Change MDS assessment with ARD of 4/10/24 revealed section Z0500 was signed by the RN Assessment Coordinator and verified completion of the assessment on 4/26/24, 2 days late. 3. Resident #227 was admitted to the facility on [DATE]. Review of the resident's Admission MDS assessment with ARD of 6/23/24 revealed section Z0500 was signed by the RN Assessment Coordinator and verified completion of the assessment on 7/09/24, 9 days late. 4. Resident #228 was admitted to the facility on [DATE]. Review of the resident's Admission MDS assessment with ARD of 6/30/24 revealed section Z0500 was signed by the RN Assessment Coordinator and verified completion of the assessment on 7/19/24, 12 days late. 5. Resident #233 was admitted to the facility on [DATE]. Review of the resident's Admission MDS assessment with ARD of 6/30/24 revealed it was incomplete and in progress. Section Z0500 was not signed by the RN Assessment Coordinator and verified as complete. On 7/24/24, the assessment was 7 days late. On 7/25/24 at 11:04 AM, the MDS Coordinator explained the facility's process was to review the MDS in progress list each morning with the Interdisciplinary Team (IDT) where she reminded the team of the due dates and incomplete sections. She checked residents #82, #88, #227, #228, and #233's medical record, and acknowledged their most recent MDS assessments were completed late. She said it was important to submit all MDS assessments to the Centers for Medicare and Medicaid Services (CMS) timely to accurately report residents' current status. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/25/24 at 11:07 AM, the Regional Director of Clinical Reimbursement said she provided support to the facility for MDS assessments completions. She explained, the facility was behind and experienced difficulties in getting some of the specialized sections completed on time. She stated the facility's process was to follow the CMS Resident Assessment Instrument (RAI) guidelines which outlined the timeframes required for completion and submission. Review of the facility's standards and guidelines titled, MDS N-1025 and dated 9/25/17 read, The center conducts initial and periodic standardized, comprehensive and reproducible assessments no less than every three months for each resident including, but not limited to the collection of date regarding functional status, strengths, weaknesses and preferences using the federal and/or state required RAI.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident’s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) Quarterly Assessments were completed within the regulatory time frame for 2 of 8 residents reviewed for Resident Assessment, of a total sample of 40 residents, (#63, #111). Findings: 1. Resident #63 was admitted to the facility on [DATE]. Review of the resident's Quarterly MDS assessment with an Assessment Reference Date (ARD) of 6/11/24 revealed section Z0500 was signed by the Registered Nurse (RN) Assessment Coordinator and verified completion of the assessment on 7/18/24, 23 days late. 2. Resident #111 was admitted to the facility on [DATE]. Review of the resident's Quarterly MDS assessment with ARD of 6/27/24 revealed section Z0500 was signed by the RN Assessment Coordinator and verified completion of the assessment on 7/18/24, 7 days late. On 7/25/24 at 11:04 AM, the MDS Coordinator explained the facility's process was to review the list each morning with the Interdisciplinary Team (IDT) where she reminded the team of MDS assessment due dates and incomplete sections. She checked the medical record and acknowledged resident #63 and #111's assessments were completed late. She said for approximately 3 months, since she started working at the facility, there were issues with some of the sections getting completed on time. She explained, the facility followed the the Resident Assessment Instrument (RAI) guidelines for time frames. On 7/25/24 at 3:10 PM, the Regional Director of Clinical Reimbursement checked the facility's MDS assessments in progress list, and conveyed there were multiple additional incomplete and late assessments. On 7/25/24 at 2:44 PM, the Director of Nursing (DON) explained the facility was aware of ongoing late MDS assessments and noted they did not currently have a Social Worker. The DON stated, moving forward, we have a plan in process. Review of the facility's job description titled, MDS Nurse-LPN (Licensed Practical Nurse) I read, . 5. Complete required documentation in an accurate and timely manner. Review of the facility's standards and guidelines titled, MDS N-1025 and dated 9/25/17 read, The center conducts initial and periodic standardized, comprehensive and reproducible assessments no less than every three months for each resident including, but not limited to the collection of date regarding functional status, strengths, weaknesses and preferences using the federal and/or state required RAI.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on observation, interview, and record review, the facility failed to ensure oxygen (O2) therapy was administered as per physician orders for 2 of 2 residents reviewed for oxygen therapy of a total sample of 40 residents, (#327, #90). Findings: 1. Resident #327 was admitted to the facility on [DATE] with diagnoses to include heart failure, atrial fibrillation, cardiomyopathy, and shortness of breath. The Minimum Data Set (MDS) 5-day assessment with Assessment Reference Date (ARD) dated 7/25/24 revealed a Brief Interview for Mental Status, (BIMS) of 15 which indicated the resident was cognitively intact. The assessment noted the resident received oxygen. Review of the resident's clinical record noted physician orders dated 7/20/24 for continuous oxygen at 2 liters per minute. Observations on 7/22/24 at 9:52 AM and 12:53 PM revealed the oxygen concentrator was set at 4.5 liters per minute. On 7/22/24 at 1:15 PM, Licensed Practical Nurse (LPN) observed resident #327 oxygen concentrator and acknowledged it was set at 4.5 liters per minute. She stated the resident's oxygen should have been at 2 liters. She said she usually checked the oxygen rate when she was in the room but was running behind today and could not explain who set the oxygen at 4.5 liters. She acknowledged the resident could not have increased the rate because she could not reach the concentrator. On 7/22/24 at 1:22 PM, the Unit Manager (UM) confirmed that resident #327 should have been on 2 liters of oxygen. She said she expected nurses to check the liter flow when they were in the resident rooms. The UM stated the nurse should also verify the physician order in the clinical record to ensure it is the correct liter flow. On 7/25/24 at 2:50 PM, the Director of Nursing stated her expectation was that the nurse would know the resident was on oxygen and know the liter flow of oxygen the resident should receive. She stated she also expected the nurse to check the oxygen liter flow when in the room to ensure the oxygen was at the correct rate. 50401 2. On 7/22/24 at 9:40 AM, resident #90 was lying in bed with the head of bed slightly elevated. There was an oxygen concentrator machine in the resident's room with bag attached containing oxygen tubing dated 7/19/24. The resident did not have nasal canula on and the oxygen was not being used. On 7/23/24 at 10:45 AM, the oxygen concentrator remained in the resident's room. The oxygen was not being administered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Review Report showed oxygen was ordered on 7/10/24 at 2-4 liters per minute via nasal cannula continuous every shift. On 7/23/24 at 12:47 PM, LPN A stated the oxygen order dated 7/9/24 was for 2-4 liters per minute continuously. She said the oxygen was started the other day when the resident did not look well and was leaning to one side. She added, the resident's oxygen saturation level measured 94 today. She explained that with the current oxygen saturation level, she would set the oxygen flow rate at 2 liters/minute. LPN A also noted the resident was known to pull the nasal cannula out. Upon entering the resident's room, the resident was observed leaning to one side. The oxygen concentrator was turned off and the nasal canula was not connected to the concentrator. LPN A did not explain why the resident's oxygen was not being administered or why the concentrator and the oxygen tubing was not attached. On 7/23/24, review of the physician orders noted the previous oxygen order was discontinued after it was brought to the facility's attention. A new physician order for oxygen noted oxygen at 2 liters as needed (PRN). On 7/24/24 at 11:29 AM, Registered Nurse (RN) D stated she was the RN for the resident on Monday 7/22/24. She acknowledged the resident did not receive oxygen as per physician orders on 7/22/24. She explained she was told the resident's oxygen sats were up, so oxygen was not needed. The electronic Medication Administration Record (MAR) indicated the same order for oxygen, 2-4 liters via nasal cannula continuously with start date of 7/10/24 and discontinued date of 7/23/24 at 2:34 PM. It also indicated oxygen was signed off as provided to this resident by nursing staff for all shifts from 7/10/24 through when it was discontinued on 7/23/24. The facility's Oxygen Therapy policy noted oxygen therapy must be reviewed by the nurse on a regular basis, the nurse will organize the oxygen therapy as ordered by the physician, and will document the time the oxygen started, the flow rate, and the resident's response to the oxygen therapy.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on observation, interview, and record review, the facility failed to maintain adequate communication with the dialysis center and ensure post-dialysis assessments were completed for 1 of 4 residents reviewed for dialysis of a total sample of 40 residents, (#56). Findings: Review of the medical record revealed resident #56 was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included end-stage renal disease (ESRD) with dependence on dialysis, and type 2 diabetes. Review of the Minimum Data Set (MDS) Quarterly assessment with Assessment Reference Date (ARD) of 6/01/24 revealed resident #56's Brief Interview for Mental Status (BIMS) score was 15 out of 15 which indicated intact cognition. The assessment showed the resident had no behavioral symptoms and did not reject evaluation or care that was necessary to achieve his goals for health and well-being. The assessment revealed resident #56 required dialysis. Review of the medical record showed resident #56 received dialysis treatments every Monday, Wednesday and Friday. Review of the Dialysis Communication Record showed 3 sections, the first and third were to be completed by the facility's nurses and the middle section was to be completed by the dialysis center. There were multiple Dialysis Communication forms missing from January to June 2024. Review of 8 forms provided for January showed 1 of 8 forms contained no documentation from the dialysis center and 4 of 8 forms had incomplete documentation in the facility sections. Review of communication forms for February 2024 showed 2 forms had no documentation from dialysis on either form and 1 of 2 forms were missing documentation from the facility. March 2024 forms noted 1 of 2 forms were missing dialysis documentation and both forms had incomplete documentation from the facility. There were 5 forms provided for April 2024 and 4 of 5 forms had no documentation from dialysis and all 5 forms were missing documentation from the facility. There were 8 forms for May 2024 and 6 of 8 forms had no documentation from the dialysis center and 5 of 8 forms were missing documentation from the facility. June 2024 showed 4 forms and 2 of 4 forms had no dialysis documentation and 2 of 4 forms were missing documentation from the facility. Of the 29 forms reviewed for a 5-month period, only 8 forms had all three areas completed. Review of the progress notes did not reveal any contact made with the dialysis center. On 07/25/24 at 11:06 AM, Licensed Practical Nurse A explained the facility sent a communication form with the resident to dialysis. She said the facility nurse completed the top portion of the form prior to the resident leaving the facility and the dialysis center completed the middle portion of the form. She said the facility nurse would complete the bottom portion of the form when the resident returned from dialysis. She stated if the dialysis staff did not complete the form, the facility nurse was to send the form back to the dialysis center for completion. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/25/24 at 11:48 AM, the 100 hall Unit Manager (UM) stated if the communication record was returned with incomplete information, the dialysis center should be called and the form should be sent back. The UM reviewed several of the communication records and acknowledged they were not complete. She stated she had emailed the dialysis center multiple times regarding the incomplete communication records but did not get a response to her emails. The UM explained when she called the dialysis center, she spoke to a nurse but the communication forms continued to come back with no documentation. She was not able to explain why so many of the communication records were missing documentation form the facility nurses and the dialysis center. She stated her expectation was for the nurses to complete the documentation when the resident returned from dialysis and for the nurse to inform the dialysis center when the communication records were not completed. The Policy and Procedure, Coordination of Hemodialysis Services dated 11/30/14 and revised on 7/02/19 read: The dialysis Communication form will be initiated by the facility for any resident going to an End Stage Renal Dialysis (ESRD) center for hemodialysis. Nursing will collect and complete the information regarding the resident to send to the ESRD center. The ESRD facility is to review the Dialysis Communication Form and either: a. Complete the communication form and return with the resident or b. Provide treatment information to the facility. Upon the resident's return to the facility, nursing will review the Dialysis Communication form and information completed by the dialysis center or the information sent by the dialysis center; communicate with the resident's physician and other ancillary departments as needed, implement interventions as appropriate. Nursing will complete the post dialysis information on the Dialysis Communication form and file the completed form in the Resident's Clinical Record.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35086 Based on record review, and interview, the facility failed to identify and report a medication for hypotension (low blood pressure) was given when it should have been held 110 times over a 4-month period for 1 of 5 residents reviewed for unnecessary medications, (#38). Findings: Review of the medical record revealed resident #38 was admitted to the facility on [DATE] and then readmitted from acute care hospital on 6/4/23. The resident had diagnoses that included hypotension (low blood pressure), chronic hepatic failure, diabetes mellitus type 2, cirrhosis of the liver, chronic obstructive pulmonary disease, hypertension (high blood pressure) and portal hypertension. Review of resident #38's physician order to start on 4/2/24 directed nurses to administer Midodrine (medication to treat low blood pressure) 10 milligrams by mouth every 8 hours for hypotension, give for systolic blood pressure (SBP) less than 110 millimeters of mercury (mmhg). The resident's care plan revised on 5/24/24 for hypotension with the goal that she would be free of signs and symptoms of hypotension and intervention included to give medications as ordered. Review of the Consultant Pharmacist Medication Regimen Reviews showed the pharmacist recommended to order specific parameters for Midodrine on 3/30/24, and the physician gave orders to hold for SBP less than 110 mmhg. Review of the medication administration records (MARs) showed the nurses failed to hold the medication 110 times from 4/3/24 to 7/24/23 and the failed to identify nurses were not following parameter orders for 4 months until brought to their attention at time of survey. On 7/24/24 at 2:29 PM, the assigned day Registered Nurse (RN) D said she had just taken resident #38's BP which was 118/73 mmhg and administered the 2 PM dose of Midodrine. The RN acknowledged that she made errors by giving medication when it should have been held per parameter orders 7 times in July, 7 times in June, 5 times in May and 6 times in April. RN D said she thought she made an error because usually the parameter to hold Midodrine is for SBP less than 130 mmhg. The RN then pulled the pill card on her medication cart that read, hold if BP less than 110. The RN verified that she knew that Midodrine was used to help raise BP and did not know why she made errors. On 7/24/24 at 2:45 PM, the Director of Nursing (DON) reviewed resident #38's MARs from April to July and validated that multiple nurses over 2 shifts did not hold Midodrine as ordered, and noted the pharmacist should have picked up on the errors as during their monthly review. The DON validated the pharmacist had not reported any discrepancies to date regarding the nurses administering Midodrine and not holding per physician ordered parameters. On 7/25/24 at 06:35 AM, a telephone interview was conducted with night Licensed Practical Nurse (LPN) C. Review of the MAR showed this nurse had given Midodrine when it should have been held 10 times in July, 7 times in June, 7 times in May and although she only worked 1 week in April she made 3 errors. The LPN was not aware Midodrine was used to raise BP. She noted, I should have looked it up. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/25/24 at 7:14 AM, a telephone interview was conducted with night LPN B who said she had only worked on the unit that resident #38 resides 2-3 times per month as she normally worked on other side of the facility. She was informed that she made errors regarding administering Midodrine to the resident when her SBP was over 110 mmhg three times in July, twice in June and one time in April. LPN B said she knew if the BP was low that Midodrine will help raise it and thought the parameter to hold medication was for SBP under 120 mmhg and did not realize the order was for 110 mmhg. On 7/25/24 at approximately 10 AM, an interview was conducted with day LPN A who was resident #38's usual day nurse. She said, she did not realize that on 7/5/24 at 10 PM, she gave Midodrine when the resident's BP was 124/84 and on 6/21/22 at 2 PM, when the BP was 119/55. She acknowledges not following physician parameter orders and said she would be more careful as she knew the medication was used to raise BP. On 7/25/24 at 10:35 AM, the Consultant pharmacist explained, Midodrine is typically given to raise blood pressure when needed. She explained she did monthly reviews of the residents MARs as well as random audits and did not identify the nursing staff were not giving Midodrine to resident #38 per parameter orders from April to July 2024. She agreed the nurses should look up medications they were not familiar with to find out the indication and possible side effects. The Consultant added, she needed to do some education with nursing staff as well as observe them do medication administration pass. She noted the potential reaction or adverse effect of not giving Midodrine as ordered was high blood pressure and increased risk of stroke. The facility policy for Administering Medications revised April 2019, read Medications are administered in a safe and timely manner, and as prescribed . Each nurses' station has a current Physician's Desk Reference [PDR] and or other medication reference .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50401 Based on observation, and interview, the facility failed to ensure dishes were handled in a manner to prevent bacterial growth, specifically that cups, bowls, pellet bases, and lids were air dried between use. FINDINGS: On 7/22/24 at 2:32 PM, during tour of the kitchen, observations were made of plastic pellet bases wet nesting and a row above the dish machine counter with cups and bowls inverted on trays that would not allow to completely air dry. At this time, Dietary Aide I stated the bases were kept there to dry and were stacked on top of each other next to the tray line for service. When one of the base was removed from the other, the base was noted to be wet. Upon observing the wet-nested dishes, the Dietary Manager stated he needed liners between dishes and trays and needed to have a different method to store bases to prevent wet-nesting. He stated it was important to have air flow between dishes and trays and between the bases so bacteria would not grow.