STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106032	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Sarasota	1507 S Tuttle Ave Sarasota, FL 34239

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 41155 Based on observation, staff and resident interviews and review of facility policies and procedures, the facility failed to ensure 1(Resident #21) of 1 resident reviewed had a wheelchair in good working repair and was safe for resident use. The findings included: The facility policy Wheelchair (w/c) Repair-Electric Wheelchairs documented, Each resident requiring the use of a w/c will be provided the appropriate chair to maintain their highest level of functioning. All chairs will be maintained in a safe operating condition. When identified that the w/c is in need of repair, the staff will notify rehab to obtain a replacement w/c while the chair is being repaired. Preventive maintenance of each w/c should be done on a regular basis and the Director of Environmental Services should keep a log of this. On 12/10/24 at 12:59 p.m., Resident #21 was observed in his w/c, and said he needed a new w/c because his required repair. The resident got up from the w/c and it was observed to have a broken back support that did not provide the necessary support. The arm rests were frayed and covered in black tape. The seat was torn, frayed and tattered. He said he had requested a new w/c multiple times and has not received one. Resident #21 said he felt the w/c was dangerous and not safe. He said he was worried he could fall backwards due to the lack of support with the w/c. On 12/10/24 at 4:47 p.m., during an interview, the Regional Nurse Consultant (RNC) said she and the Director of Nursing did assess the residents w/c. The RNC said they were not aware of the condition of the resident's w/c, and would order him a new w/c. On 12/11/24 at 10:52 a.m., during an interview, the Maintenance Director (MD) said he is notified of things in need of repair in the facility electronic Tell's system. He said the staff are to report repairs using the Tell's system. The MD said there was no log at this time where staff can write their concerns for maintenance. The MD said the process for broken w/c's was to take it to the therapy department and they would determine if the w/c was able to be repaired or needed to be replaced. He said Resident #21 had reported to him for days that he needed a new w/c, and I told him to go to therapy, there was no way that chair could be fixed. On 12/11/24 at 11:55 a.m., during an interview, the Maintenance Director said, he inspected Resident #21's w/c and went to therapy to obtain a new w/c. The MD said he threw the old w/c in the garbage because there was no way to repair the w/c so he replaced it. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Photographic evidence obtained.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on observations, interviews, and record review the facility failed to provide appropriate housekeeping services to ensure the facility remained in good repair, and ensure facility staff were aware of how to report needed repairs to the maintenance staff. The findings included: 1. On 12/09/24 at 10:52 a.m., a large brown stain was observed on the carpet in the living room area adjacent to room [ROOM NUMBER]. There was a tear in the carpet noted with carpet material being frayed and sticking up above the carpet. The area of carpet torn was approximately 2 to 3 inches wide. On 12/11/24 at 3:17 p.m., during an interview, the Housekeeping Director said the stain in the 507-living area pod was caused by the air conditioner leaking. The Housekeeping Director said he had talked to maintenance about replacing the carpet. On 12/11/24 at 3:21 p.m., during an interview, the Maintenance Director said his plan is to replace all the carpets with hardwood flooring. The Maintenance Director said he has a hard time getting the approval to do the work. 2. On 12/10/24 at 9:43 a.m., an observation of room [ROOM NUMBER] showed the light behind the bed was not working. There was a vanity over a dresser in front of the room in which one of the four light bulbs were not working. Resident #104 said the light over her bed had not been working since she moved into the room [ROOM NUMBER] months ago. On 12/11/24 at 11:05 a.m., during an interview, the Maintenance Director was asked how staff report needed repairs to maintenance. The Maintenance Director said as of about three weeks ago the facility had switched to using Tells to communicate repairs electronically. He said he did not know if staff had been in-serviced on using the Tells system. On 12/12/24 at 10:03 a.m., during an interview Certified Nursing Assistant, Staff D, said she would use the maintenance book at the nurse's station to communicate to maintenance a repair was needed. On 12/12/24 at 10:10 a.m., during an interview Registered Nurse, Staff E said she would document the repair needed in the maintenance book at the nurse's station. On 12/12/24 at 10:15 a.m., during an interview Registered Nurse, Staff F said she would notify maintenance by documenting in the maintenance book at the nurse's station. 41155 On 12/9/24 at 9:15 a.m., during initial observations of the 400 hall on the South Unit, the following was noted: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. room [ROOM NUMBER] the top to the toilet tank was missing. There was a wash basin on the floor with a roll of toilet paper, in it. 4. room [ROOM NUMBER] there was a plunger on the floor next to the toilet and a wash basin on the floor. 5. room [ROOM NUMBER] there was a wash basin on the floor under the sink. There were three bottles of personal care liquids and an adult brief on the sink in a shared bathroom. 6. room [ROOM NUMBER] there was a wash basin on the floor under the sink in a shared bathroom. 7. room [ROOM NUMBER] there were 2 urinals hanging from the trash can. There was peeling paper, exposing the dry wall next to the head of the bed. 8. room [ROOM NUMBER] there was a urinal with urine in it hanging inside of the trash can. There was oxygen tubing lying across the trash can. On 12/9/24 at 10:00 a.m., during an interview, Certified Nursing Assistant Staff O said he did not know why the urinal was in the garbage and said he thought the resident liked having it there. Photographic evidence obtained.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. 41155 Based on review of the clinical record, review of facility policy and procedures, and resident and staff interviews, the facility failed to protect residents from misappropriation of resident property when controlled medications were unaccounted for 1(Resident #45). On 2/13/24 it was reported Resident #45's Hydrocodone-Acetaminophen 5 milligrams (mg)-325 mg, 75 tablets were unaccounted for. The facility failed to account for all controlled medications to prevent loss or diversion. On 8/5/24 controlled medications were signed out on the narcotic declining drug inventory sheet as administered for 3(Resident #12, # 42, and #27) who were alert and oriented and reported they had not received the medications that were documented. On 10/2/24 Resident #63 reported he received a medication that was not his Oxycodone- Acetaminophen 10 mg-325 mg and had not requested the as needed medication from the nurse who documented it was administered. The findings included: The facility policy N-1265 Abuse, Neglect, Exploitation and Misappropriation documented It is inherent in the nature and dignity of each resident at the center that he or 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. Misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful, temporary, permanent use of a residence belongings or money without the residents consent. Employee misappropriation includes but is not limited to: diversion of residents medication(s) including but not limited to controlled substances for staff use or personal gain. The facility policy N-861 Acceptance of Controlled Drugs documented, Controlled drugs will be delivered to the facility by the pharmacy in a sealed, tamper proof container. One nurse will sign for the container on the pharmacy delivery sheet. The container will remain sealed until a second nurse is available to open and validate the contents. 2 nurses will open the controlled drug container and reconcile the controlled drugs including but not limited to: correct medication, dosage, amounts. Controlled medications are then placed into the medication carts by the nurses. If discrepancies are found during reconciliation notify the pharmacy and the director of nursing. Discrepancies may include but are not limited to: missing controlled drugs incorrect quantities, damaged containers or seals, tote is open or there is evidence of tampering. 1. Review of the facility investigation documented on 2/13/24 Resident #45's Hydrocodone-Acetaminophen 5 milligrams (mg)-325 mg, 75 tablets were unaccounted for. Licensed Practical Nurse (LPN) Staff E attempted to administer Hydrocodone-Acetaminophen 5 mg-325 mg to Resident #45, but was not able to locate the medication in the medication cart. Staff E contacted the pharmacy to order the medication and was notified of a delivery of 75 tablets on 2/6/23. The medication was signed as received on the pharmacy manifest on 2/6/24 by LPN Staff L. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff E notified Unit Manager LPN Staff M and a search of the facilities five medication carts and two medication rooms was conducted. Staff M contacted the pharmacy to confirm the medication was delivered to the facility. The Hydrocodone-Acetaminophen 5 mg-325 mg, 75 tablets were not located. The advanced practice registered nurse (APRN) was contacted for a new order for the missing medication. The facility did not substantiate the investigation due to the allegation was refuted by evidence collected during the investigation. Based on staff and resident interview and full house audit on current residents receiving narcotics ensured no other narcotic medication were misplaced. The facility investigation was inconclusive. Review of the witness statement written by LPN Staff L with a date of 2/14/24 documented I gave the med's to assigned on that cart. I cannot remember anything after that. Review of the phone interview witness statement dated 2/19/24 received by the Regional Nurse Consultant for LPN Staff P documented, She thinks she remembers receiving narcotics from Staff L but cannot verify or remember if anything was for Resident #45. Review of the Pharmacy delivery form documented 75 Oxycodone 10 mg tabs were delivered and signed for by LPN Staff L. On 12/11/24 at 9:30 a.m., the Director of Nursing (DON) said resident interviews were conducted on LPN Staff L's assignment and no other residents receiving pain medications had any issues. Staff L is no longer employed with us. Staff P was the nurse Staff L said she gave the medications to, and she is no longer here either. The DON said the process when the pharmacy delivers medications to the facility a nurse signs electronically, that the medications were received. The pharmacy keeps the record, but a copy is in our electronic dashboard system. We did notify the pharmacy the Hydrocodone was missing and they will follow up. The investigation is a facility thing. I think we found the medication but there is no documentation it was found. We never had to replace it because we found it in the pharmacy bag that is returned to the pharmacy. We searched the medication rooms and did not find the medication until later. The DON confirmed there was no documentation stating the facility had located the medication. The DON said we interviewed all the residents when the medication was not discovered, and we closed the investigation out. She said the root cause of the missing 75 tablets of Hydrocodone/Acetaminophen 5/325 was the nurses were not having a witness when they sign the narcotics in and out, so we implemented that they need to have a second nurse witness. Education was provided with the nurses on the policy of having 2 nurses sign for the medications. Review of the facilities resident interview sheets consisted of the residents name and the question are you receiving your pain medication? circle yes/no. No dates, no time and no signatures were on the facility audits. Review of the education in-service provided on 2/14/23 by the Unit Manager LPN Staff M, specified 2 nurses will sign all narcotic sheets when received from pharmacy and before entering the sheet into the narcotic binder. Nine nurses including the presenter signed the attendance sheet. LPN Staff M signed for nine nurses who were provided with a phone call regarding the policy. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/24 at 1:46 p.m., Resident #45 said she was informed by the facility staff her pain medication was missing. She said she had pain in her back, and they did not have her medication that evening. She said she was informed that if she wanted a refill, she would have to pay for the medication. Resident #45 said that is not my problem, they need to find out who took my medications, the nurse is the one with the keys not me. I can't unlock the cart. On 12/11/24 at 2:19 p.m., LPN Staff M showed the plastic bag the medications go into for return to the pharmacy. She said the pharmacy delivers medications daily and collects the go back bags. 2. On 12/9/24 at 11:50 a.m., RN Staff J, he said was working on 8/6/24 and when I came in and counted the cart with LPN Staff I, and the count was good. I noted residents who don't ask for controlled medications had received them. Resident #12 never complains of pain and I saw that Tramadol 50 mg was signed off on the declining controlled drug count sheet and one hour later a Hydrocodone/Acetaminophen 5/325 mg was signed off as well. Both medications were scheduled every 4 hours as needed and Resident #12 received the 2 medications 1 hour apart. I asked the resident, and he said he never requested a pain pill. Resident #27 had two Oxycodone 20 mg tablets removed from the medication card but only one tablet was signed out. Resident #42 had one Ativan 0.5 mg removed from a full card of 25 tablets. Resident #42 has never used the medication, he never asks for it. I looked at the count sheets and I thought something was suspicious because I asked the residents, and they all said they did not receive the medications. I went to the DON with my concerns, and we conducted an audit of all the medication carts to make sure the controlled medication count sheets were accurate. We interviewed the residents, and they said they never requested the medications and did not receive them. On 12/9/24 at 2:00 p.m., Resident #12 he said he remembers the nurse who said she gave me Tramadol and Hydrocodone. She said I asked for the pills and I never asked for the medication, and she never gave me anything. I didn't get any medications that night. Resident #12 said the nurse tried to say she gave them to him but he did not receive them. He said They sign it out and say they give it but they don't. It is our word against the nurses. 3. On 8/5/24 at 9:04 p.m., LPN Staff I documented she administered one Oxycodone 20 mg tablet to Resident #27. The facility reviewed the declining narcotic count sheet and a new card of 25 pills showed 2 tablets were removed, leaving a total of 23 pills left in the card. The facility was not able to locate the missing Oxycodone 20 mg. 4. On 8/5/24 at 00:00 LPN Staff I documented she administered one Ativan 0.5 mg (medication used to treat anxiety or agitation) to Resident #42. The medication was scheduled as needed. Review of the declining controlled medication count sheet revealed the pharmacy delivered 25 tablets on 6/29/24. The facility verified the medication was removed from the medication card and declining narcotic count sheet had been filled out correctly but the resident said he did not ask for the medication or receive it. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/24 at 10:53 a.m., Resident #42 said I know I have not ever requested an Ativan from any nurse here. That night, I don't remember the exact date, but the nurse said she gave me an Ativan and I asked for it, but she never gave me anything. I think maybe she took it or gave it to someone else but not me. The resident said RN Staff J had asked him if he requested and received the Ativan, and I told him I did not get an Ativan from the nurse. On 12/11/24 at 8:30 a.m., the DON said she investigated the event of 8/5/24 with the medications for Residents #12, #27 and #42. She said it was the night shift nurse, Staff J who found the discrepancies with medications which were signed out for residents who do not usually receive them. The DON said, with Resident #12, Staff I had signed the declining narcotic count sheet for a Tramadol 50 mg at 9:00 p.m., and an hour later at 10:00 p.m., a Oxycodone/325 was signed out. Staff J said the resident never asks for the medications and asked him if he had received them. The resident said he had not received them and did not ask for them. The DON said, we checked the count sheet, and the Tramadol and Oxycodone were signed out. I interviewed LPN Staff I and she said she gave it because Resident #12 had asked for it. I interviewed Resident #12 and he said he did not receive the medications, and did not ask for them. He has the capacity to know if he received the medications or not. The DON said, Resident #27 had an unopened card of Oxycodone 20 mg tablets. There were 25 tablets. Staff I gave 1 tablet but, 23 tablets were left indicating Staff I gave 2 pills. She said she only gave one. I interviewed the resident but she could not recall how many pills she received that night. The declining narcotic control count sheet indicated 23 tablets remained. Resident #42 had Ativan .5 mg ordered as need, and one tablet was signed out at 00:00 by Staff I on 8/6/24. Staff J said the resident had never asked for an Ativan before and asked the resident and he said he did not request it or receive it. The DON said, with these three residents identified, we interviewed the nurse and realized she had made multiple medication errors that night. I was not able to determine if she took the medications or gave them to other residents or to the right residents. Staff I said, she had a horrible night with family issues and said she probably should have called off. She said she kept leaving the unit to cry and was upset. Staff I said she gave the medications to Resident #12, #27 and #42. After the investigation I was not able to identify what happened. Staff I did not come in for her scheduled interview and did not show up for her scheduled shift. I attempted to contact her multiple times but she did not return my calls. The DON said the root cause was inconclusive. The facility was not able to substantiate medication diversion. 5. Review of the facility investigation revealed on 10/2/24 at 6:30 a.m., Resident #63 reported a potential discrepancy in his medication administration to the facility nurse, LPN Staff S. He reported he received 3 pills in the medication cup, including his scheduled levothyroxine and Gabapentin. The third pill was marked with a G and numbers, and did not match the appearance of his prescribed as needed Hydrocodone-Acetaminophen 10/325 mg. He suspected the pill was not his prescribed pain medication. Resident #63 reported to the DON and the Social Service Director, that LPN Staff N entered his room and stated she had his morning medications and a pain medication. The resident said he did not request the as needed pain medication. Resident #63 said the Nurse handed him the cup and left the room. The facility investigation was documented as inconclusive. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12 /9/24 at 12:30 p.m., during an interview, Resident #63 said on 10/2/24, I remember that day very well. LPN Staff N brought me 3 pills in a cup. I identified 2 of them, they were correct. The third one she said was my pain pill. I know I get Hydrocodone 10/325 and the pill has an M on it with some numbers. She gave me a round pill with the letter G on. My pain medication is not round it is long and white. I keep up with my medications, you have to so when things like this happen you are aware. The DON said it was a Tylenol pill that she gave me, I don't know what it was but I refused to take it. There was no Hydrocodone given to me that night. I filed a grievance regarding the incident. I know my medications; you have to be able to look at your pills and know what you are getting. You have to be your own advocate. Review of the medication administration record for October 2024 documented at 10:20 p.m., on 10/2/24 the nurse signed the Hydrocodone-Acetaminophen 10/325 mg was administered to Resident #63. On 12/9/24 at 12:00 p.m., review of Resident #63's pain medication with LPN Staff R. The Hydrocodone-Acetaminophen 10/325 did have the letter M 367 inscribed on the tablet. On 12/11/24 at 08:30 a.m., during an interview, the DON said on 10/2/24 Resident #63 reported to the nurse he received a medication with the letter G on the round tablet. He did have an order for Gabapentin and levothyroxine that he takes at 6:00 a.m. He said the nurse gave him a cup with three pills and said one was a pain pill but he never asked for a pain pill. We did a pain scale and reviewed his medication. He described the pill and one of the nurses determined it was a Mucinex tablet. One of the nurses knew what the Mucinex tablets we have in stock look like and that is what he described. He did not have an order for Mucinex. I don't know if he received the medication it was inconclusive to me. I did not know if the resident took the medication or the nurse did. The DON said she did not do education with the staff as it was an isolated situation. On 12/12/24 at 9:28 a.m., The Quality Assurance Performance Improvement (QAPI) binder was reviewed with the Administrator, and the DON. There was no documentation in the binder of anything discussed in the monthly QAPI meetings. There was no documentation for February and March 2024 regarding the missing tablets of Hydrocodone/Acetaminophen 5/325 75 for Resident #45, and no plan of correction. The DON said we did not bring it to QAPI because we found the medication later but we have no documentation the medication was found. I educated the staff on the 2 person system for checking in medications received from the pharmacy and when removing narcotics from the cart. There were no QAPI notes regarding the reportable event of 8/6/24 with missing narcotics for Residents #12, #27 and #42. The Administrator said he did not know about the missing Hydrocodone/Acetaminophen 5/325 75 for Resident #45 because he was hired in March 2024. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no QAPI discussion for the 10/2/24 reported incident of Resident #63 receiving a Mucinex tablet in place of the Oxycodone 10/325 mg tablet. I knew about that, he received a Mucinex tablet and not the pain medication. He said, I am not a nurse so I don't know about medications, I leave that for the DON to handle. The Administrator said he kept typed notes in the electronic record for the QAPI meetings because his handwriting was not good but he was not able to find any QAPI notes for the medication diversion. He said the DON handled the QAPI for the reported event on 8/6/24. It was a newly hired nurse, and we reported it. He confirmed there was no documentation of the incident discussed in QAPI. The Administrator said he reported it to the State agency, that is it. The Administrator said we discovered it was newly hired nurses who made medication mistakes so the DON and I are interviewing the new hires and we are more intuitive. If we get a bad feeling about the person or something does not feel right, we don't hire them. On 12/12/24 at 10:20 a.m., the DON she said everything with the medications was traced back to newly hired nurses not our nurses. I did education and I believe it was effective, but I understand there is no documentation of the outcome. It was not taken to QAPI because it was not our nurses who were making the mistakes so there was not anything we could have done for that. I don't see how we could have. We found the missing medications for Resident #45 but we did not document it when they were found. The incident on 8/5/24 occurred because Staff I was a new nurse. We completed assessments of the residents. The DON confirmed the declining narcotic sheets for Resident #27, #12 had the dates crossed out and another date written over it. The DON said that was another error Staff I made that evening. On 12/12/24 at 5:01 p.m., in a telephone interview, the Pharmacy Consultant said he is at the facility monthly and reviews the resident charts and medications and makes recommendations. He said he was not made aware of the missing 75 Oxycodone 5/325 tablets for Resident #45. He said this is the first time I'm hearing about it. I did not know. The Pharmacy Consultant was informed of the event on 8/5/24 of controlled medications signed out to Resident #12, #27 and on 8/6/24 signed out for Resident #42 who reported they had not received the medications. He said Oh gosh I did not know, no one mentioned any of this to me. The Consultant said he was not aware of Resident #63's concern with his pain medication and confirmed the Hydrocodone 10/325 mg did have the letter M and numbers on the tablet. He said I did not know about any of this. If needed I could have worked with the facility to make suggestions on how to prevent the problems. If needed I would have been in QAPI.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Record Review (PASARR) Level I and Level II were conducted prior to admission to the facility for 1 resident diagnosed with serious mental illness (#79) of 2 residents reviewed for PASARR. The findings included: Review of Resident #79's medical record revealed original admission to the facility on [DATE]. The physician's orders dated 9/2/22 included psychiatry and psychology (consultations) as needed. The psychiatric diagnoses present on admission included: major depressive disorder, recurrent, mild on 9/1/22; psychophysiologic insomnia on 9/1/22. On 1/11/23, the physician ordered that the resident be sent to the emergency room related to altered mental status (AMS) including hallucinations, delusional and combative behaviors. On 1/11/23 the facility added the diagnosis of psychotic disorder with delusions due to known physiological condition. On 1/14/23 the facility added the diagnosis of major depressive disorder, single episode, severe with psychotic features. On 2/27/23 the facility added the diagnosis of anxiety disorder, unspecified. Review of the psychiatric consult note from [area hospital] dated 1/12/23 revealed the resident was hospitalized for behavioral disturbances at the nursing facility. The patient was noted to become emotionally unstable in the emergency room and started yelling with obvious auditory hallucinations. Review of the facility comprehensive assessment dated [DATE] Section A revealed Resident #79 had entered the facility from a general hospital and was not evaluated for PASARR Level II for indications of serious mental illness. Review of Section I of the assessment revealed Resident #79 had diagnoses of anxiety, depression, and psychosis. Review of the physician's orders revealed active orders for the antipsychotic medications Haloperidol 1 milligrams (mg) every 6 hours as needed for agitation, nausea/vomiting, hiccups; Seroquel 50mg every 12 hours as needed for psychosis/paranoia related to psychotic disorder with delusions due to known physiological condition; and Seroquel XR 50mg in the evening. Review of the psychiatrist consultation dated 11/22/24, revealed Resident #79 was seen for a gradual dose reduction (GDR) of psychiatric medications, which is recommended for the age group. The psychiatrist concluded the GDR was not recommended and the resident would become unstable if medications were reduced. Resident #79's diagnoses for consultation included: Psychotic disorder with delusions due to known physiological condition. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 9:20 a.m., a review of Resident #79's medical record at the facility including paper chart and electronic health record revealed there was no PASARR Level I screening or PASARR Level II screening for Resident #79. 12/12/24 at 3:25 p.m., during an interview, the Social Services Director (SSD) said he could not locate a PASARR Level I screening in the medical record. He said he thinks the resident has some mental illness. He said before the resident was admitted to the facility, the resident was not receiving any special services for mental illness. The SSD said there is no PASARR Level I in the chart. He said there is no PASARR Level II in the chart. He said he is not qualified to perform the pre-admission screening. He said he looked in the medical record department for any indication a Level I was completed, and he said he did not find one. On 12/12/24 5:33 p.m., during an interview, the Administrator said a PASARR Level I should be in the chart. He said it is the responsibility of the nursing team to make sure the PASARRs are in the chart when the resident is admitted .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on interview and record review, the facility failed to formulate a comprehensive resident-centered care plan that included the services required to ensure proper functioning and maintenance including monitoring, testing, and ways to identify potential problems or complications for 2 (Residents #9, and #22) of 2 reviewed in the facility who had implanted cardiac pacemakers. The findings included: Review of the Policy for Pacemaker, monitoring of Resident, revised 9/5/17, nursing services will coordinate and assist with pacemaker checks for residents with pacemakers. The procedures included identifying residents with pacemakers and obtaining an order from the physician for routine scheduled pacemaker checks based on manufacturer or physician's order or recommendation. Document in the medical chart. Review of the Policy for Plans of Care revised 9/25/17: The procedures included developing a comprehensive plan of care including measurable objectives and timetables to meet the resident's medical needs that are identified in the comprehensive assessment. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest physical, mental and psychosocial well-being. The person-centered care plan may include but is not limited to the following: Services to attain or maintain the highest practicable physical, mental, and psychosocial well-being as required by state and federal regulatory requirements; and individualized interventions that honor the resident's preferences and promote achievement of the resident's goals. Review of the Hospital Cardiology Consult Note for Resident #9 dated 8/4/24 revealed Resident #9 was an [AGE] year-old with a history of atrial fibrillation, prior pacemaker implantation, and non-sustained ventricular tachycardia (fast heart rate). If stable, the plan included conservative management. Resident #9 was discharged from the hospital and admitted to the facility on [DATE]. The quarterly resident assessment completed by the facility on 11/13/24 revealed diagnoses including hypertension and hyperlipidemia, renal (kidney) insufficiency, diabetes, and hemiplegia or hemiparesis (paralysis on one side of the body). There was no diagnoses listed for atrial fibrillation or presence of cardiac pacemaker in the resident assessment. Review of the physician's order summary for Resident #9 revealed there was the presence of a cardiac pacemaker. There were no instructions or orders for the care of the device. Review of the comprehensive care plan for Resident #9 initiated on 8/22/24 revealed the resident wished to remain in the facility for long-term care. The interventions included to encourage the resident to discuss feelings and concerns .; establish a pre-discharge plan .; and evaluate and discuss with the resident or the representative the prognosis for independent or assisted living; identify, discuss and address limitations, risks, benefits, and needs for maximum independence. There were no interventions in the care plan for maintaining the proper functioning of the cardiac pacemaker. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #9's nutrition care plan revealed the resident was at risk of malnutrition related to the presence of the pacemaker. The interventions included did not specify instructions to ensure the proper care of the pacemaker. Review of Resident #9's care plan for advanced directives initiated on 8/22/24 revealed the resident did not want cardiopulmonary resuscitation and maintained a Do Not Resuscitate (DNR) status at the facility. The care plan interventions for the DNR status did not include any interventions for the cardiac pacemaker. Review of Resident #9's care plan for terminal prognosis initiated on 12/9/24 revealed comfort, dignity, and autonomy will be maintained at the highest level through the review dated. Interventions included working cooperatively with the hospice team to ensure physical needs are met. There were no interventions or instructions regarding the cardiac pacemaker. On 12/9/24 at 11:31 a.m., Resident #9 was observed in the bedroom. The resident's room did not contain a remote cardiac monitoring device for the pacemaker that would send signals to the doctor's office for monitoring the resident's heart rate. On 12/9/24 at 1:37 p.m., during an interview with Resident #9's health care surrogate, she said the pacemaker was checked in the hospital. She said before that, the resident had not been to the cardiologist in about 2 years. She said she attends the care plan meetings, but the facility has not mentioned any pacemaker checks or cardiology appointments scheduled for Resident #9. She said she does not know anything about the current care or plan for the pacemaker. 12/12/24 9:31 a.m., during an interview with Licensed Practical Nurse (LPN) Staff Q, she said she worked at the facility since March 2024. She said she works on different units in the facility and had taken care of Resident #9 in the past. She said she was not aware of any residents in the facility with pacemakers and usually does not deal with pacemakers. She said she would check the vital signs frequently if the resident had a pacemaker. On 12/12/24 at 9:41 a.m., during an interview with the Minimum Data Set (MDS) Coordinator, she said she is part of the interdisciplinary team and attends the morning meetings with the team. She said the 24-hour report is discussed as well as new orders and she makes sure care planning interventions are initiated when necessary. She verified the pacemaker diagnosis on the physician's order summary. She said there should be a care plan for the cardiac pacemaker. She looked through the resident's electronic and paper medical chart and said there was no care plan or order for routine checks. She said there should be a care plan and that she would add one. On 12/12/24 at 10:17 a.m., during an interview with the Director of Nursing (DON), she said she would expect to see physician's orders for cardiology follow-up and order from the physician for heart rate range, trouble shooting and maintenance. She said she could not find any information other than that listed in the hospital record. The resident does not have a care plan for maintenance of the device. Review of the medical record for Resident #22 revealed and admission to the facility on [DATE]. The annual comprehensive assessment dated [DATE] revealed diagnoses of atrial fibrillation (irregular heartbeat), coronary artery disease, hypertension, and hyperlipidemia. The diagnoses did not include the presence of a cardiac pacemaker. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #22's physician order summary revealed the diagnosis of presence of cardiac pacemaker. There were no orders for checking or maintaining the device. Review of the care plans for Resident #22 revealed ones for congestive heart failure, fluid overload related to heart failure, and anticoagulant therapy related to atrial fibrillation and coronary artery disease. None of the care plans had instructions for how the facility was providing care and services for the resident's pacemaker. On 12/12/24 at 10:45 a.m., during an interview, the MDS coordinator confirmed Resident #22 medical record at the facility did not include a care plan for maintenance of the resident's implanted cardiac pacemaker. .

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of clinical records and resident and staff interviews, the facility failed to assist in making an appointment with a practitioner specializing in the treatment of vision impairments and failed to ensure the resident's glasses were in good repair for 1(Resident #95) of 1 resident reviewed for vision loss. The findings included: Review of the clinical record revealed resident #95 had diagnoses including morbid obesity, type 2 diabetes and acute vision changes. On 12/10/24 at 10:24 a.m., Resident #95 was observed with broken glasses that were taped together on both sides of the arms to the frame. Resident #95 said he has requested to see the eye doctor multiple times, but is told he needs to wait because his insurance does not cover it. Resident #95 said I can only tape them so much before they break completely. I don't see why it is so hard to get an appointment. I was sent to the hospital on 11/27/24 because the pain in my left eye was so bad, and they sent me back here. I can't see well out of my left eye, and I don't see well out of the right eye, just shadows. Review of the physician orders revealed a standing order for Optometry/ophthalmology as needed. The clinical record showed on 11/27/24 Resident #95 was sent to the local emergency department for evaluation of the left eye visual disturbance. The discharge summary dated 11/30/24 documented the resident would require additional ophthalmologic workups. High suspect of patient's visual changes would either be related to hypertensive retinopathy or diabetic retinopathy. Pt appears to have poor insight in regards to his overall health and social situation. Pt has the belief that all of his medical symptoms should be completely resolved and or treated by the time he leaves the hospital. Pt notes good improvement of the vision along his left eye and along with improved visual acuity of the right eye. Recommend ophthalmology evaluation when possible given weekend holiday, it is possible that care may be faster on a outpatient basis. The discharge summary instructed to follow up with ophthalmology to schedule appointment. Review of the clinical record showed no documentation the resident had been seen by the ophthalmologist and no documentation the follow up appointment had been arranged. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 8:45 a.m., during an interview the Social Service Director (SSD) said it was difficult to find a physician to accept Resident #95's medical insurance. The SSD said the facility did have an eye doctor who will see residents at the facility, and he was responsible for scheduling the in house appointments with the eye doctor. The SSD said he knew the residents' eyeglasses were broken and new ones were coming in the mail. The eye doctor sends the eyeglasses by mail and will e-mail me a copy of the visit with the resident. The SSD said he would contact the eye doctor to see when Resident #95's glasses would arrive. Review of the SSD progress note with a date of 12/11/24 at 9:11 a.m., documented SS emailed the eye doctor to follow up on glasses of when going to be delivered. On 12/11/24 at 11:21 a.m., during an interview the SSD said he was not able to locate any information regarding new glasses for the resident. I emailed the eye doctor and I'm waiting to hear back. The nurses are helping to make appointments, but he does not have the follow up appointment scheduled right now. He was sent to the hospital recently and they said his eyes were fine there was nothing wrong with his eyes. The SSD said the Director of Nursing (DON) would schedule the follow up appointment with the ophthalmologist. On 12/11/24 at 11:35 a.m., during an interview an interview the DON said the resident reported a problem with his vision and he wanted to go to the eye specialist. When we contacted the eye doctor the resident no longer had insurance and could not be seen. The resident had recently changed his insurance to a different company, and it did not include a vision program. I spoke to the resident and I let him know what was going on with the appointment and the resident said he did have a vision plan with the new insurance and he would look for the card. I told him I would schedule the appointment if he could find his insurance card. He said he wanted to go to theER on [DATE], he said he could not locate the insurance cards. I told him the facility would pay for the appointment and at that time he said he did not want to wait, and he wanted to go to the emergency room (ER). I tried to educate him that the ER was for emergencies, and he might not get the care he is seeking (an eye specialist) but he insisted to go so we had to send him. Since he returned, we are trying to schedule an appointment for him and I believe the nurse is working on it. As for the glasses, I was not aware they were taped on both sides. The SSD is the one who handles routine eye visits and appointments for eyeglasses.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 . Based on observation, interview, and record review the facility failed to ensure one (Resident #104) urinary catheter was secured to allow a free flow of urine to the catheter bag and prevent movement and pulling of the catheter line. Consistent pressure and pulling on the catheter line has a potential to cause irritation to the urethra and contribute to increased urinary tract infections. The findings included: According to the Center for Disease Control 2009 Catheter-Associated Urinary Tract Infections (CAUTI) Prevention Guideline it is strongly recommended to properly secure urinary catheters after insertion to prevent movement and urethral traction [pressure, or pulling]. Resident #104 is a [AGE] year-old female admitted to the facility on [DATE] with a history of Spinal Cord Compression, Intervertebral Disc Degeneration, Neuromuscular Dysfunction of the Bladder, Major Depressive Disorder, Anxiety Disorder Severe Protein Malnutrition, and Constipation. The Quarterly Minimum Data Set, dated dated dated [DATE], Section C shows a Brief Mental Interview Status (BIMS) of 15 which shows no cognitive deficits. Section H shows Resident #104 has an indwelling urinary catheter. Resident #104 is care planned for an indwelling urinary catheter related to a Neurogenic Bladder. The goal is for the resident to be free from catheter related trauma through the review date of 1/11/25. The intervention listed did not include to secure the catheter to prevent movement and pulling. The Kardex (communication tool used to communicate to aide's resident's daily needs) did not list catheter care or securing the catheter to the resident's leg. On 12/10/24 at 9:46 a.m., Resident #104's catheter line was observed to be unsecured to the resident. Resident #104 said she has not had a catheter strap attached to her to secure the catheter all week. On 12/12/24 at 10:40 a.m., the urinary catheter was observed not secured to the resident's leg. Resident #104 verified staff had not attempted to place catheter strap to secure the catheter line. On 12/12/24 at 10:55 a.m., during an interview, Registered Nurse, Staff E said catheter straps were available to secure catheter lines of resident's with urinary catheters. RN Staff E said she was not aware Resident #104 did not have a catheter strap in place. On 12/12/24 at 11:00 a.m., during an interview the Central Supply Aide verified catheter straps were available for residents with catheters.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 30599 Based on observation, interview, an record review, the facility failed to post nursing staff two consecutive days and failed to post accurate numbers of nursing staff on two additional days. The findings Included: On 12/9/24 at 9:10 a.m., the federal posting was observed in the lobby of the facility. The last posted date noted was 12/6/24. Review of the federal postings for 11/16/24, and 11/17/24 showed on both dates there were 13 Certified Nursing Assistants (CNA) listed as working on the morning, and the evening shifts. Review of the two-week staffing hours provided by the facility showed on 11/16/24 there were 12 CNA's working on both the morning and evening shift. On 11/17/24 there were 12 CNA's working on the morning shift, and 11 working on the evening shift. On 12/11/24 at 9:50 a.m., during an interview, the Staffing Coordinator said it was the responsibility of the weekend supervisor to update the federal postings on the weekends because she did not work on the weekends.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41155 Based on staff interviews, and review of the facility policy and procedures, the facility failed to implement a system to account for periodic reconciliation and disposition of all controlled substances. The findings included: The facility Policy N-864 Control Drug Reconciliation Random Audit documented The facility in coordination with the licensed pharmacist provides for: A system of medication records that enables periodic accurate reconciliation and accounting for controlled medications. Prompt identification of loss or potential diversion of controlled substances and determination of the extent of the loss or potential diversion of controlled medications. On 12/11/24 at 10:15 a.m., during an interview, the Director of Nursing (DON) said the process for narcotic medications was to have two nurses' sign when narcotics are received and two nurses sign when the medication is discontinued or the medication card is empty. The DON said she collects the discontinued medications from the medication carts weekly, the nurse and I sign the declining count sheet and then I place the medications in a double locked drawer here. The DON said the pharmacist and I destroy the medications once a month. The DON said she was not able to reconcile the controlled medications currently stored in the locked drawer. She said I would have to open the drawer, pull the count sheets and look at the medication cards to tell you that. The DON confirmed she had no process in place to provide an accurate accounting of the medications kept in a locked drawer in her office.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 41155 Based on review of the clinical record, review of facility policies and procedures, and resident and staff interviews, the facility failed to ensure accuracy of medication administration for 17(Residents #122, #222, #70, #41, #97, #13, #92, #10, #61, #8, #46, #67, #74, #12, #27, #63 and #42) of 17 residents reviewed for significant medication errors. The findings included: The facility policy N-861 Acceptance of Controlled Drugs documented, Controlled drugs will be delivered to the facility by the pharmacy in a sealed, tamper proof container. One nurse will sign for the container on the pharmacy delivery sheet. The container will remain sealed until a second nurse is available to open and validate the contents. 2 nurses will open the controlled drug container and reconcile the controlled drugs including but not limited to: correct medication, dosage, amounts. Controlled medications are then placed into the medication carts by the nurses. If discrepancies are found during reconciliation, notify the pharmacy and the director of nursing. Discrepancies may include but are not limited to: missing controlled drugs incorrect quantities, damaged containers or seals, tote is open or there is evidence of tampering. 1. On 12/9/24 at 11:50 a.m., during an interview, Registered Nurse (RN) Staff J, said he was working on 8/6/24. He said, when I came in and counted the cart with LPN Staff I, the count was good. I noted residents who never request controlled medications had received them. Resident #12 never complained of pain and I saw that Tramadol 50 mg was signed off on the declining controlled drug count sheet. One hour later a Hydrocodone/Acetaminophen 5/325 mg was signed off as well. Both medications were scheduled every 4 hours as needed and Resident #12 received the 2 medications, 1 hour apart. I asked the resident, and he said he never requested a pain pill. Resident #27 had two Oxycodone 20 mg tablets removed from the medication card but only one tablet was signed out. Resident #42 had one Ativan 0.5 mg removed from a full card of 25 tablets. Resident #42 has never used the medication, he never asks for it. I looked at the count sheets and I thought something was suspicious because I asked the residents, and they all said they did not receive the medications. I went to the DON with my concerns, and we conducted an audit of all the medication carts to make sure the controlled medication count sheets were accurate. We interviewed the residents, and they said they never requested the medications and did not receive them. 2. On 12/9/24 at 2:00 p.m., during an interview, Resident #12 he said he remembers the nurse who said she gave me Tramadol and Hydrocodone. She said I asked for the pills and I never asked for the medication, and she never gave me anything. I didn't get any medications that night. Resident #12 said the nurse tried to say she gave them to him but he did not receive them. He said They sign it out and say they give it but they don't. It is our word against the nurses. 3. On 8/5/24 at 9:04 p.m., LPN Staff I documented she administered one Oxycodone 20 mg tablet to Resident #27. The facility reviewed the declining narcotic count sheet and a new card of 25 pills showed 2 tablets were removed, leaving a total of 23 pills left in the card. The facility was not able to locate the missing Oxycodone 20 mg. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Aspire at Sarasota		STREET ADDRESS, CITY, STATE, ZIP CODE 1507 S Tuttle Ave Sarasota, FL 34239	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 8/6/24 at 00:00 LPN Staff I documented she administered one Ativan 0.5 mg (medication used to treat anxiety or agitation) to Resident #42. The medication was scheduled as needed. Review of the declining controlled medication count sheet revealed the pharmacy delivered 25 tablets on 6/29/24. The facility verified the medication was removed from the medication card and the declining narcotic count sheet had been filled out correctly but the resident said he did not ask for the medication or receive it. On 12/10/24 at 10:53 a.m., during an interview, Resident #42 said I know I have not ever requested an Ativan from any nurse here. That night, I don't remember the exact date, but the nurse said she gave me an Ativan and I asked for it, but she never gave me anything. I think maybe she took it or gave it to someone else but not me. The resident said RN Staff J had asked him if he requested and received the Ativan, and I told him I did not get an Ativan from the nurse. On 12/11/24 at 8:30 a.m., the DON said she investigated the event of 8/5/24 with the medications for Residents #12, #27 and #42. She said it was the night shift nurse, Staff J who found the discrepancies with medications signed out for residents who do not usually receive them. Regarding Resident #12, The DON said Staff J saw he had a Tramadol 50 mg at 9:00 p.m., and an hour later at 10:00 p.m., a Oxycodone/325 was signed out. Staff J said the resident never asks for the medications and asked him if he had received them. The resident said he had not received them and did not ask for them. We checked the count sheet, and the Tramadol and Oxycodone were signed out. I interviewed LPN Staff I and she said she gave it because Resident #12 had asked for it. I interviewed Resident #12 and he said he did not receive the medications, and did not ask for them. He has the capacity to know if he received the medications or not. With Resident #27 she had an unopened card of 25 Oxycodone 20 mg tablets. The nurse gave 1 tablet but 23 tablets were left indicating Staff I gave 2 pills but she said she only gave one. I interviewed the resident but she could not recall how many pills she received that night. Resident #42 had Ativan 0.5 mg as need and one tablet was signed out at 00:00 by Staff I. Staff J said the resident had never asked for an Ativan before and asked the resident and he said he did not request it or receive it. With Residents #12, #27 and #42 we identified the errors. When we interviewed the nurse we realized she had made multiple medication errors that night. I was not able to determine if she took the medications or gave them to other residents or to the right residents. She said she had a horrible night with family issues and said she probably should have called off. She said she kept leaving the unit to cry and was upset. Staff I said she gave the medications to Resident #12, #27 and #42. After the investigation I was not able to identify what happened. All the residents on her assignment had medication errors and they did not receive their scheduled medications. LPN Staff I signed the medications as administered for all scheduled medications for the residents on her assignment. She said she gave the medications to Residents #122, # 222, #70, #41, #97, #13, #92, #10, #61, #8, #46, #67, and #74 and signed the Medication Administration Record (MAR). We interviewed the residents who were alert and they said they did not receive any medication from the nurse. The Mars were signed on 8/5/24 for Residents #122, #222, #70, #41, #97, #13, #92, #10, #61, #8, #46, #67, and #74 that the medications were administered, but the residents denied receiving any medications. (continued on next page)

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	106032	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Sarasota	1507 S Tuttle Ave Sarasota, FL 34239

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of the facility investigation revealed on 10/2/24 at 6:30 a.m., Resident #63 reported a potential discrepancy in his medication administration to the facility nurse LPN Staff S. He reported he received 3 pills in a medication cup, including his scheduled levothyroxine and Gabapentin. The third pill was marked with a G and numbers and did not match the appearance of his prescribed as needed Hydrocodone-Acetaminophen 10/325 mg. He suspected the pill was not his prescribed pain medication. Resident #63 reported to DON and Social Service Director, that LPN Staff N entered his room and stated she had his morning medications and a pain medication. The resident said he did not request the as needed pain medication. Resident #63 said the Nurse handed him the cup and left the room. Facility investigation was documented as inconclusive. On 12 /9/24 at 12:30 p.m., in an interview, Resident #63 said on 10/2/24, I remember that day very well. LPN Staff N brought me 3 pills in a cup. I identified 2 of them, they were correct. The third one she said was my pain pill. I know I get Hydrocodone 10/325 and the pill has an M on it with some numbers. She gave me a round pill with the letter G on. My pain medication is not round it is long and white. I keep up with my medications, you have to so when things like this happen you are aware. The DON said it was a Tylenol pill that she gave me, I don't know what it was but I refused to take it. There was no Hydrocodone given to me that night. I filed a grievance regarding the incident. I know my medications; you have to be able to look at your pills and know what you are getting. You have to be your own advocate. Review of the medication administration record for October 2024 documented at 10:20 p.m., on 10/2/24 the nurse signed the Hydrocodone-Acetaminophen 10/325 mg was administered to Resident #63. On 12/9/24 at 12:00 p.m., review of Resident #63's pain medication with LPN Staff R. The Hydrocodone-Acetaminophen 10/325 did have the letter M 367 inscribed on the tablet. On 12/11/24 at 8:30 a.m., during an interview, the DON said on 10/2/24 Resident #63 reported to the nurse he received a medication with the letter G on the round tablet. He did have an order for Gabapentin and levothyroxine that he takes at 6:00 a.m. He said the nurse gave him a cup with three pills, and said one was a pain pill but he never asked for a pain pill. We obtained a pain scale and reviewed his medication. He described the pill and one of the nurses determined it was a Mucinex tablet. One of the nurses knew what the Mucinex tablets we have in stock look like and that is what he described. He did not have an order for Mucinex. I don't know if he received the medication it was inconclusive to me. I did not know if the resident took the medication or the nurse did. The DON said she did not do education with the staff as it was an isolated situation.

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	106032	A. Building B. Wing	12/12/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41155 Based on observations, review of facility policies and procedures and staff interviews, the facility failed to ensure medications were stored in a safe and secure manner within the facility, including medication carts and resident rooms. The findings included: The facility policy N-853 Medication- Oral Administration of, documented Prepare medication for one resident at a time . Do not use the resident room or bed number as a resident identifier as these may change. Document the administration and acceptance or decline of all medications administered. 1. On 12/9/24 at 9:05 a.m., during an observation of the North medication Cart #2 with Licensed Practical Nurse Staff H, in the top drawer of the cart were three clear, plastic medication cups with unidentified pills. One medication cup had crushed medications in apple sauce. Two other medication cups were stacked on top of each other. The LPN removed the top pill cup with 6 unidentified pills. The bottom pill cup had 7 unidentified pills. The medication cups had room numbers on each cup of medications. The LPN said the residents were not in their rooms so I put the medications in the drawer so I could administer them later. Photographic evidence obtained. 2. On 12/9/24 at 10:36 a.m., Resident #59 was observed with a medication cup containing 1 whole white pill and a half of a white pill in a medication cup on his bedside table. There was an unidentified and unlabeled inhaler with the unidentified pills. Photographic evidence obtained. On 12/10/24 at 11:10 a.m., Resident #59 was noted to have his top nightstand drawer open and 3 medications were observed stored in the drawer: one Symbicort inhaler160/4.5. Fluticasone Propionate nasal spray, 50 micrograms per spray. A bottle of Besivance antibiotic eye drops. Photographic evidence obtained. Review of the clinical record revealed Resident #59 did not have an order to self administer the medications.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on observation, interview and record review the facility failed to ensure an effective pest control program to prevent flying insects and roaches within the facility. The findings Included: Resident #104 is a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #104's quarterly MDS dated [DATE] shows a BIMS score of 15 which shows no cognitive deficits. On 12/10/24 at 9:43 a.m. Observation's in Resident #104's room noted small insects were flying around the resident's bed in room [ROOM NUMBER]. Resident #104 said she had seen the flying insects in her room for at least two weeks. Resident #104 said she has roaches coming in her room from around the air conditioner. Resident #78 is a [AGE] year-old male who was admitted to the facility on [DATE]. The Annual Minimum Data Set (MDS) dated [DATE] shows Resident #78 had a Brief Mental Interview Status (BIMS) score of 13 which shows his cognition to be intact. On 12/10/24 at 11:35 a.m., during an interview, Resident #78 said he sees roaches in his room at times. Small flying insects were observed flying around the resident's bed in room [ROOM NUMBER]. Resident said he had seen the flying insects around his trash can in his room near his bed for the last year. On 12/11/24 at 11:05 a.m., during an interview, the Director of Maintenance said it was an ongoing battle to keep pests out of the building. He said the sleeves around the air conditioner units in the rooms have been stripped out and it leaves openings in the rooms for insects to get in the building. On 12/12/24 at 11:00 a.m., the Director of Maintenance only could provide documentation of the pest control company's report of treatment for November of 2024. Documentation had been requested for the last three months. There was no documentation on the November report to show the pest control company was treating flying insects in resident's rooms. On 12/12/24 at 1:00 p.m., the pest control logbook at the nurse's station on the 600 hallway showed the last time the pest control company was at the facility was on 12/9/24. rooms [ROOM NUMBERS] were not listed in the logbook to be treated for pests.