STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106074	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Kissimmee Gardens	1120 W Donegan Ave Kissimmee, FL 34741

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on observation, interview, and record review, the facility failed to promote dignity in dining for 3 of 3 residents reviewed for dignity, of a total sample of 46 residents, (#77, #86, and #265). Findings: 1. Review of resident #77's medical record revealed she was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, mild protein-calorie malnutrition, and dysphagia. Review of resident #77's Minimum Data Set (MDS) annual assessment with Assessment Reference Date (ARD) of 3/18/24 revealed a Brief Interview for Mental Status (BIMS) score was not obtained because she was rarely/never understood. The MDS assessment noted resident #77 was totally dependent on staff for all activities of daily living (ADLs), including eating. Review of resident #77's care plan, initiated on 7/12/22, revealed she had an ADL self-care performance deficit related to Alzheimer's disease, generalized weakness, gait/balance problems, and incontinence. On 4/15/24 at 12:32 PM, Certified Nursing Assistant (CNA) E was observed feeding resident #77 while standing by her bed. At 12:36 PM, CNA E continued feeding resident #77 while standing. Later at 12:47 PM, CNA E stated she had 3 residents who needed eating assistance on today's assignment. She indicated she, Sometimes sits, otherwise remains standing while helping the resident, whatever is more comfortable, to her. She explained she received her training in CNA school and was oriented by another CNA when hired by the facility. She stated she never had any issues standing up to feed residents before. On 4/15/24 at 12:58 PM, and 1:11 PM, Unit Manager (UM) G was also observed feeding resident #77 while standing next to her bed. 2. Review of resident #86's medical record revealed he was admitted to the facility on [DATE] with diagnoses including stroke, aphasia (inability to speak), dysphagia (difficulty swallowing), Alzheimer's disease, dementia, and failure to thrive. (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: 106074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #86's MDS quarterly assessment with ARD of 3/06/24 revealed a BIMS score was not obtained because he was rarely/never understood. The MDS assessment noted resident #86 was totally dependent on staff for all ADLs, including eating. Review of resident #86's care plan, initiated on 1/09/23, revealed he had an ADL self-care performance deficit related to previous stroke, aphasia, lack of coordination, and dementia. On 4/15/24 at 12:28 PM, resident #86 was seated in bed eating lunch assisted by UM G who was standing next to him. On 4/15/24 at approximately 5:35 PM, CNA F was observed assisting resident #86 to eat while she stood next to his bed. At 5:47 PM, CNA F stated she did not have much space to place a chair next to the bed, so she stood and fed him. She confirmed she was supposed to be seated while assisting residents to eat. 3. Review of resident #265's medical record revealed she was readmitted to the facility on [DATE] with diagnoses including Parkinsonism, anxiety, and contractures of the left elbow, left wrist, and left and right hands. Review of resident #265's MDS quarterly assessment with ARD of 1/22/24 showed a BIMS score of 15 out of 15 which indicated she was cognitively intact. The MDS assessment revealed resident #265 was totally dependent on staff for ADLs, including eating. Review of resident #265's ADL self-care performance care plan initiated on 4/15/24 revealed she was totally dependent on staff for eating. On 4/15/24 at 12:25 PM, and 12:33 PM, CNA D was observed standing next to resident #265 assisting the resident to eat lunch while she sat in a recliner chair. On 4/15/24 at 1:02 PM, CNA D stated she preferred to stand while assisting residents to eat because she was busy. CNA D referred to resident #86 as a, Feeder, who ate well during the conversation about other residents who required eating assistance. She asked, How can I be seated to assist them? She indicated in Florida it was up to the CNA if they wanted to sit or not while assisting residents to eat. CNA D stated she did not recall if this was discussed during her facility orientation. On 4/16/24 at 11:14 AM, UM G stated staff usually stood up next to the residents when they assisted them to eat. She explained there were not always chairs available in the rooms. She mentioned it was important to be at eye level with residents to observe their eating, and therefore she preferred to be, Up and ready to go. She stated she was not aware of any specific requirements about assisting residents to eat. She said she guessed, It all depends. She noted she had previously seen CNAs standing while assisting residents to eat and had not had an issue with it. On 4/17/24 at 11:10 AM, the Director of Nursing stated he provided education to all new staff upon hire. He explained a Skills Competency Assessment: Eating Support form was conducted for all CNAs upon hire and annually. He reviewed the form and stated it did not specify staff should be seated versus standing because of the resident's right to dignity, only that CNAs needed to sit to be at the same level as the resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Skills Competency Assessment: Eating Support revealed CNA D, E, and F met the competency by direct observation or return demonstration and fully met standards on 9/08/23, 1/10/24, and 11/15/23 respectively. Review of the Roadmap / New Hire Orientation: All Staff Mandatory Education/Information to be Provided form revealed UM G received education on Understanding Resident Rights on 11/07/23. Review of the policy and procedures titled Resident Rights dated 11/30/14 read, It is the policy of The Company to. Ensure that resident' rights are known to staff. The policy included ongoing resident rights training would be given to staff members.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on observation, interview, and record review, the facility failed to ensure an evaluation for self-administration of medication was conducted and failed to obtain a physician's order for self-administration of medication for 1 of 10 residents reviewed for choices, of a total sample of 46 residents, (#30). Findings: Resident #30 was admitted to the facility on [DATE], with diagnoses which included poly-osteoarthritis, hypertension, adjustment disorder with mixed anxiety and depressive mood, bilateral artificial knee joint, and hyperlipidemia. Review of the resident's quarterly Minimum Data Set assessment with Assessment Reference Date of 2/05/24, revealed the resident's cognition was intact, with a Brief Interview For Mental Status score of 13 out of 15. Observations on 4/15/24 at approximately 12:04 PM, and on 4/16/24 at 5:14 PM, showed a container of Biofreeze gel on resident #30's tray table. The resident stated she used the medication on her shoulders and neck for pain approximately three to four times daily. Biofreeze (for use on the skin) is used to treat adults .to provide temporary relief of muscle or joint pain caused by strains, arthritis, bruising, or backaches (retrieved on 4/29/24 from drugs.com). On 4/16/24 at 5:16 PM, observation of the resident's tray table was conducted with Registered Nurse (RN) M. He acknowledged the Biofreeze gel on the resident's tray table, and resident #30 verbalized she used the medication on her neck, shoulders, and knees. On 4/16/24 at 5:31 PM, RN M stated residents needed a physician's order to self-administer medications, and medications were not to be kept at the resident's bedside. Resident #30's physician's orders were reviewed with RN M. He stated the resident had an order for nurses to apply Biofreeze to her bilateral knees as needed but did not have an order for the medication to be applied to her shoulders and neck. RN M confirmed a physician's order for the resident to self-administer the medication was not found. On 4/18/24 at 6:20 PM, the Director of Clinical Services stated residents needed an evaluation, and a physician's order for self-administration of medication before they were allowed to self-medicate. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy, Self-Administration of Medication at Bedside with effective date of 11/30/2014, and revision date of 8/22/2017 read, Criteria must be met to determine if a resident is both mentally and physically capable of self-administering medication and to keep accurate documentation of these actions. The procedure indicated staff should, Verify physician's order in the resident's chart for self-administration of specific medications . Complete self-administration of Medications Evaluation, and read, The MAR (Medication Administration Record) must identify meds (medications) that are self-administered .if kept at bedside, the medication must be kept in a locked drawer.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on observation, interview and record review, the facility failed to revise care plans to reflect accurate, appropriate, and individualized interventions related to showers/bathing and eating needs for 3 of 8 residents reviewed for activities of daily living (ADLs), of a total sample of 46 residents, (#31, #77 and #86). Findings: 1. Review of resident #31's medical record revealed he was readmitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction (stroke), type 2 diabetes and mood disorder. Review of resident #31's Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date (ARD) of 2/09/24 revealed he was totally dependent on staff for showers/bathing, lower body dressing and putting on/taking off footwear. Review of resident #31's care plan, revised on 8/30/22, revealed a focus on ADL self-care performance deficit related to hemiplegia, limited mobility, difficulty walking and poor communication. The interventions incorrectly noted he was able to bathe/shower with maximum assistance from staff and required moderate to maximum assistance by staff to dress. 2. Review of resident #77's medical record revealed she was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, mild protein-calorie malnutrition, and dysphagia (difficulty swallowing). Review of resident #77's MDS annual assessment with ARD of 3/18/24 revealed she was totally dependent on staff for all activities of daily living (ADLs). Review of resident #77's MDS quarterly assessment with ARD of 12/18/23 revealed she was totally dependent on staff for all ADLs. Review of resident #77's care plan, initiated on 7/12/22, revealed a focus on ADL self-care performance deficit related to Alzheimer's disease, generalized weakness, gait/balance problems, and incontinence. The interventions incorrectly noted resident #77 was able to perform eating and personal hygiene/oral care tasks with extensive assistance from staff. 3. Review of resident #86's medical record revealed he was admitted to the facility on [DATE] with diagnoses including stroke, aphasia (inability to talk), dysphagia, Alzheimer's disease, dementia, and failure to thrive. Review of resident #86's MDS quarterly assessment with ARD of 3/06/24 revealed he was totally dependent on staff for all ADLs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #86's care plan, initiated on 1/09/23, revealed a focus on ADL self-care performance deficit related to cerebral infarction, aphasia, lack of coordination, and dementia. The interventions incorrectly noted resident #86 was able to perform dressing and personal hygiene with extensive assistance from staff. It also noted he was able to eat with moderate assistance from staff. On 4/18/24 at 3:47 PM, the MDS Lead explained the MDS assessment captured how residents performed at the time of the assessment. She noted the functional assessment was completed in collaboration with therapy. She stated the care plan should reflect the results of the MDS assessment. On 4/18/24 at 4:03 PM, the MDS Coordinator stated she was responsible for participation of care plan meetings, completing MDS assessments and updating care plans. She explained care plan updates correlated with the findings of the MDS assessments. She indicated the care plan was reviewed and updated at least quarterly or sooner if needed. She stated updating the care plan was important to ensure staff provided care of residents' personal needs appropriately. She validated the care plan should have read dependent on the noted ADLs for residents #77, #86, and #31. Review of the facility's policy titled, Plans of Care revised on 9/25/17 read, An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. The procedure included review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each . MDS assessment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on observation, interview, and record review, the facility failed to identify, and obtain physician orders for treatment of non-pressure related skin conditions for 2 of 2 residents reviewed for non-pressure related skin conditions, of a total sample of 46 residents, (#42, & #56). Findings: 1. Resident #42 was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included Chronic Obstructive Pulmonary Disease, dementia, peripheral vascular disease, edema, and major depressive disorder. Review of the resident's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 3/11/24, revealed the resident's cognition was severely impaired, with a Brief Interview For Mental Status (BIMS) score of 00 of 15. The assessment indicated the resident was dependent on staff for toileting hygiene, chair/bed-to-chair transfers, and required substantial/maximum assistance to roll left/right, and for personal hygiene. On 4/18/24 at 10:00 AM, resident #42 was lying in bed on his back, Certified Nursing Assistant (CNA) N was at the resident's bedside. A gauze dressing was noted to the resident's lower left leg dated 4/05/24. On 4/18/24 at 10:26 AM, the [NAME] Hall/Sunflower Way Unit Manager (UM)-Licensed Practical Nurse (LPN) stated the resident did not have a pressure injury, and she was not aware of any wound/dressing to the resident's lower left leg. On 4/18/24 at 10:29 AM, observation of the dressing to the resident's left lower leg was conducted with the UM. She acknowledged the dressing to the resident's left lower leg dated 4/05/24, and stated she would have to change the dressing, to see what was under it. Review of the resident's physician orders conducted with the UM revealed no orders for treatment of a wound on the resident's left lower leg. Review of skin checks completed on 3/30/24, and 4/06/24 identified a wound to the front of the resident's left lower leg. However, there was no documentation to indicate the physician was made aware, nor any orders for wound care were obtained. The UM stated wound care/dressings required a physician's order, and verbalized she could not identify any orders for wound care/treatments for the resident's left lower leg. 2. Resident #56 was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included metabolic encephalopathy (brain dysfunction related to metabolism), fracture of nasal bones, diabetes type II, major depressive disorder, contracture of the right and left shoulder, atrial fibrillation, hypertension, and malignant neoplasm (cancer) of the prostate. Review of the resident's quarterly MDS with ARD of 1/15/24 revealed the resident's cognition was moderately impaired, with a BIMS score of 08 of 15. The resident required substantial/maximal assistance with personal hygiene, and partial/moderate assistance with chair to bed-to chair transfer. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 4/15/24 at 1:02 PM, 4/16/24 at 9:55 AM, and 5:26 PM, and on 4/17/24 at 10:42 AM, revealed resident #56 in bed with an undated gauze dressing on his left arm extending from his elbow to his wrist. A dried, dark rust-colored stain was noted on the dressing close to the resident's elbow. On 4/17/24 at 4:56 PM, LPN C stated the dressing to the resident's left arm was, probably, from his recent fall on 4/07/24. The resident's physician's orders were reviewed with the LPN, and she could not identify a physician's order for dressings/treatment to the resident's left arm. On 4/17/24 at 5:20 PM, the Director of Clinical Services stated he did not know what was under the dressing on the resident's left arm. The Director of Clinical Services stated review of the resident's admission assessment revealed the resident had bruises and a skin tear to his right hand, and his right antecubital. He reviewed the resident's physician orders and could not identify any order for dressing/treatment to the resident's left arm. He explained staff must have a physician order for dressings/wound care. On 4/17/24 at 5:33 PM, observation of the resident's left arm dressing was conducted with the Director of Clinical Services. He acknowledged the gauze dressing to the resident's left arm was undated and had a dried, dark rust-colored-stain near the elbow. On 4/17/24 at 5:36 PM, the Registered Nurse/Wound Care Nurse, reviewed the resident's clinical records, and shared she could not identify any documentation regarding the gauze dressing/wound care to the resident's left arm, and confirmed there were no notes by the wound care Advanced Practice Registered Nurse (APRN) to address the wound/treatment to the resident's left arm. On 4/18/24 at 9:12 AM, the Director of Clinical Services (DCS) stated the gauze dressing was removed from the resident's left arm, and skin tears to the resident's forearm, knuckles, and hand were noted. He stated the observations were identified after the resident's fall on 4/07/24, but treatment orders were not obtained and in place until 4/17/24. The DCS stated that upon readmission on 4/10/24, a nurse provided a dressing to the resident's left arm, but an order was not obtained as required. Progress note documented by the Wound Care Nurse on 4/17/23 at 7:54 PM, read, Resident with skin tear to left hand and arm. A care plan for potential for skin impairment initiated on 5/03/21 with revision on 3/22/24 revealed that staff should, Follow facility protocols for treatment of injury.

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F 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 32131

Based on observation, interview, and record review, the facility failed to ensure Occupational Therapy (OT) recommendation for Restorative Nurse Program (RNP) for Range of Motion (ROM) was initiated and maintained for 1 of 1 resident reviewed for limited ROM, of a total sample of 46 residents, (#47).

Findings:

Resident #47 was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included hemiplegia and hemiparesis following cerebrovascular disease affecting the left non-dominant side, fibromyalgia, contracture of the left hand, left elbow, and left shoulder, pseudobulbar affect, schizoaffective disorder-Bipolar type, and major depressive disorder.

Review of the resident's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date of 3/15/24 revealed the resident's cognition was moderately impaired with a Brief Interview For Mental Status BIMS score of 12 out of 15. The assessment indicated the resident had impairment in functional limitation in ROM to one side of her upper and lower extremities and was dependent on staff assistance with toileting and personal hygiene.

On 4/15/24 at 1:29 PM, resident #47 was lying in bed on her back. The resident's left hand was contracted, and a splint was not noted. The resident stated she did not have a splint, and she was not receiving therapy.

On 4/17/24 at 10:31 AM, Restorative Certified Nursing Assistant (CNA) L stated resident #47 was not on the RNP and did not have a splint.

On 4/17/24 at 11:28 AM, the Director of Rehabilitation stated the resident had contractures to her left hand and wrist, and since November 2023, the resident had not been seen by therapy. She stated the resident refused splints, and after three refusals, the splint program was stopped. The Director of Rehabilitation stated the facility's Rehabilitation company changed on 11/01/24, and resident #47 was not in therapy when the transition from one company to the other company occurred. The Director of Rehabilitation explained that when residents were discharged from therapy with a splint, the resident would be referred to the RNP. She said, if the resident refused or disliked the splint, therapy would review, and transition the resident to the RNP to continue with ROM. The Director of Rehabilitation stated the resident was not on therapy's caseload and she could not identify any documentation to indicate the resident was discharged to RNP for ROM exercises. She stated the resident's contractures had not been managed since November 2023, and acknowledged since the resident had not been on therapy caseload or the RNP, her contractures could have worsened, and a new screen would have to be done for comparison/determination.

(continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Occupational Therapy Discharge Summary with dates of service from 12/28/22 to 2/17/23 revealed resident #47 was discharged from OT and referred to RNP. Documentation for the discharge recommendations read, Restorative program for positioning and Left upper extremity ROM established and educated to Nursing and restorative staff. Prognosis to maintain CLOF (current level of function) excellent with consistent staff support, excellent with participation in RNP. On 4/17/24 at 12:00 PM, the Licensed Practical Nurse/MDS Coordinator shared that she assisted with the facility's RNP. She explained she received the communication form from therapy, coordinated data, and placed therapy's recommendation(s) as a task in the facility's electronic medical records for the Restorative CNA. A review of the resident's clinical records by the Licensed Practical Nurse/MDS Coordinator revealed no indication that resident #47 was on the RNP. On 4/18/24 at 2:36 PM, the resident's recommendation from OT was reviewed with the Director of Rehabilitation. She acknowledged the resident's discharge recommendation was for left upper extremity ROM by the RNP, and documentation indicated the task was established and education was provided to the. Nursing and restorative staff. The Rehabilitation Director stated no documentation was identified to indicate therapy recommendation for RNP was followed for the resident. The Director of Rehabilitation stated the facility did not have a policy for contracture management, but had documentation to assist with contracture management which included ROM.

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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 therapy was administered per physician orders for 2 of 2 residents reviewed for oxygen therapy, of a total sample of 46 residents, (#14 and #58). Findings: 1. Resident #14 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), and cerebral infarction (stroke). The Minimum Data Set (MDS) modification of the quarterly assessment dated [DATE], revealed a Brief Interview for Mental Status, (BIMS) of 15 which indicated the resident was cognitively intact. The assessment also reflected resident #14 received oxygen. Observations on 4/15/24 at 3:17 PM, and 4/16/24 at 10:28 AM, revealed resident #14 wearing a nasal cannula attached to an oxygen concentrator set at 6 liters per minute (LPM) of oxygen. Review of the Order Summary Report dated 3/15/23 revealed a physician's order for oxygen at 10 LPM by nasal cannula, every shift. On 4/16/24, the order was changed to oxygen at 6 LPM by nasal cannula every shift. Review of the COPD care plan indicated an intervention dated 3/15/24 and revised on 3/18/24 which described staff should follow physician orders for oxygen settings. On 4/16/24 at 10:30 AM, Unit Manager (UM) A checked her computer and stated resident #14's oxygen concentrator should be set to 10 LPM. UM A observed resident #14's oxygen concentrator in his room, and confirmed it was set at 6 LPM, not the 10 LPM ordered by the physician. The UM adjusted the oxygen flow rate of the concentrator to 10 LPM. The UM described the protocol for ensuring oxygen was delivered as ordered was the nurse should check the concentrator flow rate at the beginning of the shift. 2. Resident #58 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, heart failure, mood disorder, and anxiety. The MDS modification of the significant change assessment dated [DATE], revealed he was rarely or never understood, was severely, cognitively impaired, and received oxygen therapy. Observations on 4/15/24 at 2:00 PM and 4/16/24 at 10:27 AM, revealed resident #58 in his room wearing a nasal cannula connected to an oxygen concentrator set at 1.5 LPM. Review of the Order Summary Report dated 3/26/24 revealed an order for continuous oxygen at 2 LPM by nasal cannula. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Kissimmee Gardens	1120 W Donegan Ave Kissimmee, FL 34741

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the cardiovascular care plan indicated an intervention dated 2/09/23 and revised on 10/10/23 for oxygen settings, give oxygen as needed. The oxygen therapy care plan had an intervention dated 11/07/23, revised on 4/04/24 for staff to administer oxygen by nasal cannula per physician orders. On 4/16/24 at 10:32 AM, UM A checked her computer and stated resident #58's oxygen concentrator should be set to 2 LPM. A short time later, UM A observed resident #58's oxygen concentrator in his room, and confirmed it was set at 1.5 LPM, not the 2 LPM ordered by the physician. UM A adjusted the oxygen concentrator flow rate to 2 LPM. The UM reiterated that the nurse should check the oxygen flow rate at the beginning of the shift to ensure it was given as ordered by the physician. On 4/18/24 at 6:00 PM, the Director of Nursing stated his expectation was the nurse would follow the physician orders for oxygen settings and check the concentrator at the beginning of the shift and also with each medication administration. He explained it was important for the resident to receive the correct amount of oxygen especially for a resident with a diagnosis of COPD.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 32131 Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff was available on 2 of 3 units to meet residents' needs related to timely administration of scheduled medications, (Cliffstone and Pebblestone). Findings: Observations on 4/15/24 at 10:53 AM, and at 12:43 PM, showed Registered Nurse (RN) O at her medication cart still administering 9:00 AM medications. On 4/15/24 at 6:02 PM, RN O stated she completed the scheduled 9:00 AM medications at approximately 12:00 PM to 12:30 PM. She stated medications were supposed to be given either one hour before or one hour after the scheduled medication times. On 4/16/24 at 10:07 AM, and at 10:47 AM, RN M was observed in the process of medication administration on Cliffstone unit. On 4/16/24 at 10:50 AM, RN M stated he had three additional residents who had not received their 9:00 AM medications. He explained he was delayed because he had to explain each medication to another resident. On 4/16/24 at 11:12 AM, RN M was again observed at his medication cart. He stated he had one more resident to give 9:00 AM medications to. On 4/16/24, resident #90 was observed on the Pebblestone Unit receiving his scheduled 9:00 AM medications from Licensed Practical Nurse (LPN) J over 2 hours late at 12:08 PM. On 4/17/24 at 10:38 AM, LPN C, was observed at her medication cart on the Cliffstone unit. She stated she had twelve residents left to give 9:00 AM medications to. On 4/17/24 at 12:47 PM, LPN C stated she started working at the facility two months ago and had not worked on the Cliffstone unit in over a month. She explained she was not stationed on a specific unit, and every time she worked, she was assigned to a different unit, so she tried to familiarize herself with the new residents and their medication routines. LPN C acknowledged she completed the scheduled 9:00 AM medications about 2 hours late, at approximately 12 PM. She said it was, unrealistic to safely pass medications for 30 residents in a 2-hour window, and complete other tasks that needed her attention. She acknowledged late medications were considered a medication error if they were given after the 1 hour before or after window. The LPN explained she took her time during medication administration, to ensure she did not make a mistake. She stated she had received education from Administration that medications should be given within one hour before or one hour after the scheduled time. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/24 at 2:57 PM, late medication administration observations were discussed with the Director of Clinical Services (DCS), and the Regional DCS. The Regional DCS stated the facility had an Ad Hoc QAPI (Quality Assurance and Performance Improvement) meeting on 3/19/24 after on-time completion of medication administration was identified as a concern. The DCS and Regional DCS explained the facility had an opportunity to go to liberalized medication administration times in response to the identified concerns about late administration of medications. They described this action would take some time to put into place as processes and education to staff needed to be worked out. They shared other actions put into place including audits which included observations, helping staff with technique, cleaning up medication carts, and reducing unnecessary medications with assistance from the Medical Director. These audits were reviewed in another QAPI meeting held on 3/28/24. The DCS and Regional DCS confirmed audits, and QAPI meetings did not address staffing concerns, nor did they address actions needed to address timely administration of medications in the interim, while the facility waited to transition to liberalized medication administration times.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on observation, interview, and record review the facility failed to ensure medications were administered within the designated guidelines, and per professional standard and practices, for 2 of 7 residents observed during medication administration, of a total sample of 46 residents, (#30, & #90). Findings: 1. Resident #30 was admitted to the facility on [DATE], with diagnoses which included poly-osteoarthritis, hypertension, adjustment disorder with mixed anxiety and depressive mood, bilateral artificial knee joint, and hyperlipidemia. Review of the resident's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 2/05/24, revealed the resident's cognition was intact, with a Brief Interview For Mental Status (BIMS) score of 13 out of 15. On 4/17/24 at 5:10 PM, resident #30 said she received her scheduled 9:00 AM medications sometime around 10:30 AM depending on what the nurse was doing. Review of the resident's Medication Administration Audit Report for the period 4/15/24 to 4/17/24 revealed on 4/15/24 resident #30 received her scheduled 9:00 AM medications between 11:06 AM and 11:24 AM, which included Bupropion 300 milligram (mg) daily (QD) for depression, Metoprolol 25 mg QD for high blood pressure, and Tizanidine 2 mg twice daily for muscle spasms, a second dose of Tizanidine was administered at 5:58 PM. On 4/17/24, resident #30 received her scheduled 9:00 AM medications at 12:21 PM, which included Levofloxacin 750 mg QD for pneumonia. On 4/17/24 at 12:47 PM, Licensed Practical Nurse (LPN) C stated she knew it was a medication error if medications were given after a specific time and verbalized she took her time when administering medications, because she did not want to make a mistake. LPN C stated she was told by the Administration that medications should be given one hour before or one hour after the scheduled time. She explained it was not realistic to safely complete the medication administration in the allotted time. On 4/17/24 at 2:57 PM, the late medication administration observations were discussed with the Director of Clinical Services (DCS), and the Regional DCS. They acknowledged resident #30's scheduled 9:00 AM medications were given outside of the parameters. 43192 2. Review of resident #90's medical record revealed he was admitted to the facility on [DATE] with diagnoses including atherosclerotic heart disease, atrial fibrillation, anemia, and osteoarthritis. Review of resident #90's MDS quarterly assessment with ARD of 3/08/24 revealed a BIMS score of 12 out of 15, which indicated moderately impaired cognition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106074	A. Building B. Wing	04/18/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/24 at 12:08 PM, LPN J entered resident #90's room and told him she was there to give him his medications. She indicated she was helping his assigned nurse to pass medications. She did not tell resident #90 which medications she was giving to him. When she left the room, resident #90 asked, What was that medicine for? Review of the physician orders revealed the following medications were scheduled for administration at 9:00 AM: Aspirin 81 mg, Mirtazapine 7.5 mg, Tamsulosin 0.4 milligrams (mg), Vitamin C 500 mg, Eliquis 5 mg, Furosemide 40 mg and Metoprolol 37.5 mg. A second dose for Eliquis and Furosemide were scheduled for 10:00 PM. A second dose for Metoprolol was scheduled for 9:00 PM. Review of resident #90's Medication Administration Audit Report revealed 9:00 AM medications on 4/16/24 were actually administered at 12:08 PM. The policy Administering Medications revised April 2019 read, Medications are administered within one (1) hour of their prescribed time, unless otherwise specified.

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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 beverages and dishware were stored and served in a safe and sanitary manner to prevent foodborne illness. Findings: 1. On 4/15/24 at 9:58 AM, during the initial observation of kitchen with the Certified Dietary Manager (CDM), it was noted plate bases were placed on the drying rack stacked together without room to allow air flow for drying. Wet trays were stacked on top of each other in a pile, not allowing air flow for drying. Additionally, wet drinking glasses were placed on a tray upside down with no room between lip of glass and tray for air flow for drying. The CDM stated a tray liner was supposed to get placed between the lip of the glasses and the tray for air flow when drying. On 4/18/24 at 1:51 PM, during a follow-up kitchen observation with the CDM, plate bases were again seen placed on drying rack stacked together without room for air flow for drying and wet drinking glasses were placed on a tray upside down with no room between lip of glass and tray for air flow for drying. Tray liners the CDM had cut during the initial kitchen observation were seen piled on a cart in the corner of the kitchen away from the working area, unused. 2. On 4/15/24 at 12:40 PM, during meal observation in the dining room, a container of thickened lemon water dated 3/01 was open on the beverage cart. The Activities Director stated he provided beverages for residents at the lunch meal and the container of thickened lemon water was not present on the beverage cart when he poured the drinks. He explained if he had seen the container with the date 3/01, he would have taken it back to the kitchen to get a fresh one. The Activities Director removed the container from the dining room. A few minutes later, the CDM, the District Manager for the contracted food service management company, and the Dietary cook, came to the dining room with the aforementioned thickened liquid beverage container. They stated the 3/01 date on the container indicated when the container was received into the facility. They explained, the beverage container provided to the dining room was opened that day but acknowledged staff failed to appropriately label the container with the opened date. On 4/18/24 at 2:05 PM, the nourishment pantry on the 300 unit was observed and found to have an opened container of thickened lemon water dated 3/10. The Executive Director (ED) was present and read the directions on the container which indicated the product was to be disposed of within 7 days after opening. The ED confirmed the date on the thickened lemon water container was well past the 7 days the product could be safely kept as directed by the label. The ED disposed of the container.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 45646 Based on interview and record review, the facility failed to ensure the Quality Assessment & Assurance (QAA) / Quality Assurance and Performance Improvement (QAPI) committee conducted performance improvement activities to ensure prior improvement measures were sustained for self administration of medications. Findings: Review of the facility's QAPI Plan revealed the QAPI team would identify, collect and analyze data from different departments reflecting performance and establish benchmarks for each area. The form indicated the team would analyze the problem area by conducting a root cause analysis, identify solutions and develop a Performance Improvement Plan (PIP) to address the identified area. The PIP would include goals, actions responsible party, target dates and status/outcome with results reported monthly to the QAPI committee. Completed PIPs would be filed and monitored periodically to assure achievements were being sustained. Concerns with self-administration of medication was identified and cited at F554 on the previous recertification survey conducted 10/23/23 through 10/26/23. During this survey, concerns with self-administration of medications were again identified and the facility was found to be in noncompliance with F554. Insufficient auditing and oversight by the QAPI committee to prevent the citation was identified as a result of the repeat concerns regarding self-administration of medications. On 4/18/24 at 6:25 PM, the Administrator stated the facility constantly educated staff on medications at bedside and department heads conducted daily room rounds. She explained medications at bedside was a challenge because residents purchased them on outings or family members brought them in. She stated the department heads were supposed to look at bedside areas to identify medications during their rounds. She could not explain why medications were still found at bedside without resident assessments for self-administration of medications when facility improvement actions were in place. The Administrator acknowledged a change to the room rounds process should be addressed to identify issues found by the survey team.

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	106074	A. Building B. Wing	04/18/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on observation, interview and record review, the facility failed to provide a safe and sanitary environment while handling linens to prevent cross-contamination and spread of infection and failed to follow appropriate hand hygiene and personal protective equipment (PPE) practices per infection control standards. Findings: 1. On 4/17/24 at 3:06 PM, Laundry Attendant K was stocking a linen cart with clean bed sheets, blankets, and pads on the [NAME] unit. One sheet fell on the floor, and she picked it up, flapped it, folded it and placed it back in the cart on top of clean linens. On 4/17/24 at 3:07 PM, Laundry Attendant K acknowledged she picked up the bed sheet from the floor and placed it back with the clean linens. She stated she was not supposed to pick up items from the floor and put them with clean supplies because the floor was considered dirty. On 4/17/24 at 5:30 PM, the Housekeeping/Laundry Manager stated Laundry Attendant K told her she made a mistake and placed a dirty sheet she had picked up from the floor with the clean sheets. She explained if linens fell on the floor, the employee needed to put them in a plastic bag and leave the bag in the soiled utility room. She indicated the sheet on the floor was considered contaminated and could not be placed with the clean linens. 2. On 4/18/24 at 9:44 AM, Certified Nursing Assistant (CNA) I walked out of room [ROOM NUMBER] wearing gloves and walked into room [ROOM NUMBER] with the same gloves on. She touched the mattress, linens, and a pillow. She removed the gloves, stepped outside room [ROOM NUMBER] but did not perform hand hygiene. On 4/18/24 at 9:46 AM, CNA I stated she was a new employee who had started at the facility on 3/28/24. She acknowledged she received Infection Control education during her new hire orientation. CNA I indicated she went into room [ROOM NUMBER], checked the resident in bed B then went into the bathroom to look for a missing wallet for the resident in room [ROOM NUMBER]. She stated she was not supposed to move between rooms wearing gloves. CNA I said, That is wrong, and I should not have done it, my bad. A few minutes later, she noticed another staff sanitizing his hands, and acknowledged she should have sanitized her hands when she exited the resident's room to prevent the spread of infection. On 4/18/24 at 10:34 AM, the Infection Preventionist (IP) and the Director of Nursing acknowledged picking up linen from the floor and placing them with clean linens, wearing the same gloves from room to room, and not sanitizing hands could lead to cross-contamination and the spread of germs. The IP validated staff did not follow their Infection Control Standards. Review of the Skills Competency Assessment: Hand Hygiene revealed CNA I met the competency by direct observation or return demonstration and fully met standards on 3/26/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Infection Control Policies and Procedures revised in October 2018 read, This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Review of the policy and procedure titled Handwashing/Hand Hygiene revised in August 2019 read, This facility considers hand hygiene the primary means to prevent the spread of infections. The policy included hand hygiene was the final step after removing and disposing of PPE.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on observation, interview and record review, the facility failed to ensure a resident's bathroom was adequately equipped to allow residents to call for staff assistance through a communication system in 1 of 6 resident rooms reviewed for environmental status, (room [ROOM NUMBER]). Findings: On 4/15/24 at 12:12 PM and 4/16/24 at 5:16 PM, no call light system was noted in the bathroom shared by rooms #125 and #127. On 4/16/24 at 5:28 PM, resident #19 stated she used the bathroom by herself. She indicated she had been in the same room a few months and had not needed staff assistance while in the bathroom. She stated a resident in the other room who could not talk also used the same bathroom. Review of the Maintenance Work Orders binder in the [NAME] Hall Unit revealed there were 2 work orders for room [ROOM NUMBER] in March 2024. One of the work orders for room [ROOM NUMBER] was dated 3/26/24 for a broken toilet which was repaired on 4/01/24. On 4/16/24 at 5:49 PM, the Director of Maintenance explained his assistant worked on painting, repairing and renovating rooms. He indicated all department managers were assigned residents' rooms to inspect on a daily basis. He stated they used a mock survey sheet where they documented issues to be addressed and those were discussed during morning meetings. He explained the work orders on the nursing units were checked every day by himself or his assistant and addressed the same day. He stated call lights were located in each room by the bed and in the bathroom, some of them were next to the toilet and the showers. He indicated call lights were important in case someone fell so they could easily reach the call light and call for assistance. He explained the call lights next to the beds lit up outside the resident's room in a yellowish light color and red if the bathroom call light was activated so staff could differentiate when someone was in the bathroom. At 6:01 PM, a tour of the bathroom in room [ROOM NUMBER] with the Director of Maintenance was conducted. He stated a plate was covering the location where the call light would have been located. He mentioned that was, Probably like that for a long time. He stated he did not remember anyone mentioning to him there was no call light in that bathroom. On 4/16/24 at 6:06 PM, the Administrator stated all department managers inspected their assigned residents' room at a minimum of 3 times a day, and sometimes more often. She explained if they found something out of compliance they checked that room more often. She indicated the results of the inspections were documented in room round sheets and included checking call lights. She stated call lights should be within residents' reach near the toilet and their bed. She explained if a call light was non-functional, the resident received a call bell to use in the meantime. On 4/16/24 at 6:14 PM, an inspection of room [ROOM NUMBER] was conducted with the Maintenance Director and Administrator. Residents #19 and #97 confirmed they did not have call bells to use in the bathroom and the call lights they had were next to their beds. Administrator acknowledged there was no call system in the bathroom used by rooms #125 and #127. (continued on next page)

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	106074	A. Building B. Wing	04/18/2024

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 10:18 AM, the Assistant to the Maintenance Director recalled fixing the toilet in room [ROOM NUMBER] on 3/26/24. He explained the toilet caused a flood in the rooms and it was fixed immediately. He stated his focused was on fixing the toilet and he did not notice there was no call light system or cord in that bathroom. He indicated it was very important for the residents to have a way to call staff in case of an emergency. On 4/17/24 at 11:46 AM, the Maintenance Director stated he was unable to show evidence of call light audits. He indicated he checked the Work History Report in TELS (maintenance electronic records system) but it yielded no results. He explained some tasks were missing from his list and he had informed his Regional Director. He said regular audits of call lights were not part of his monthly inspection because it was not showing on TELS. He stated he learned of any call light issues from the mock survey observations. He indicated staff did not report it missing and his assistant did not notice it when he went to that room to fix the bathroom. Review of the policy and procedure titled Call Bell System - Inoperable reviewed on 8/22/17 read, Resident must have, at all times, a system to notify staff when assistance is needed. The call bell system is to be inspected on a regularly scheduled basis by Maintenance. If the call bell system is inoperable, in one room, one hall, or the entire unit the following procedure must be followed: Maintenance, the ED (Executive Director), and the DCS (Director of Clinical Services) must be notified immediately if any call bell or system is inoperable.