STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106116	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Bryan Dairy	9035 Bryan Dairy Rd Largo, FL 33777

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 50836 Based on observation and interview, the facility failed to ensure dignity was maintained for two (Residents #16 and #32) of 2 residents sampled for dignity out of of 61 total residents sampled. Findings included: 1. An observation was conducted on 6/9/24 at 1:00 p.m. of Resident #16 going to the smoking patio in a wheelchair wearing a hospital gown with one sock on. The resident's skin was visible from the top center of her back to the top of her buttocks. Her hair was also observed to be matted and unkempt. Review of the Admission Record showed Resident #16 was admitted on [DATE] with diagnoses including mechanical loosening of internal left hip prosthetic joint and chronic pain syndrome. Review of Resident #16's Minimum Data Set (MDS) assessment, dated 05/25/2024, Section C - Cognitive Patterns showed her Brief Interview for Mental Status (BIMS) score was 14, indicating she was cognitively intact. An interview was conducted on 6/9/24 at 4:19 p.m. with Resident #16. She stated she had not had clothes in three weeks. She said she had no family to assist her and did not come to the facility with clothes. An observation conducted on 6/10/24 at 4:10 p.m. showed Resident #16 still in a hospital gown, with matted unkempt hair. She was on the smoking patio with 12 other residents and one staff member. A follow-up interview was conducted on 6/11/24 at 10:20 a.m. with Resident #16. She said she had asked for clothes; they gave her a dress that belonged to another resident who wanted it returned. She stated the night gown she was wearing currently; they gave her on 6/10/24. The resident said, It's embarrassing to go into public areas in a hospital gown with my butt hanging out. The resident also said that she had not had a shower and it makes me feel gross. She said the first time they provided her with clothes to wear was yesterday when she was supposed to leave the facility for an appointment. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 6/11/24 at 2:46 p.m. with Staff U, Social Services Assistant. She said she was aware of three residents that wear gowns regularly throughout the day, that included Resident #16. Staff U said she gave Resident #16 extra clothes from the laundry room on 6/10/24. She also stated Resident #16 had funds that could be used for clothing. An interview was conducted on 6/11/24 at 11:28 a.m. with Staff T, Account Manager, who stated laundry generally had extra or donated clothing available. He stated if there was a situation where they could not help accommodate a resident's needs with laundry, he would notify the Nursing Home Administrator (NHA). During an interview conducted on 6/11/24 at 10:55 a.m. with Staff P, Registered Nurse (RN), Staff P stated they had donated items in laundry to provide clothing to residents when needed. She stated she had access to get resident items from donations or she would notify social services if there was a situation she could not address. During an interview conducted on 6/11/24 at 3:19 p.m., the Director Of Nursing (DON) stated she would expect if a resident had clothing needs it would be brought to her attention. She stated she had not been notified of anyone with clothing needs that the facility could not accommodate. She stated she was not aware of a resident who had been in a hospital gown for 3 weeks, who came in without any personal clothing. 46234 2. An observation was conducted on 6/10/24 at 11:26 a.m. of Resident #32 in her bed. She was noted to have on a hospital style gown and five wrist bands on her right arm and one wrist band on her left arm. The arm bands were from the hospital; there was a band labeled with her name, age, birthday, medical records number, a DNR (Do Not Resuscitate) band, a Fall Risk band, an allergy band, and a band with just her name on it. (Photographic evidence obtained.) An observation and interview was conducted on 6/11/24 at 2:14 p.m. with Resident #32. The resident was observed to still have the five wrist bands on her right arm and one wrist band on her left arm. She also remained in the same hospital style gown. The resident said the arm bands were aggravating on her arm. Review of Admission Record for Resident #32 showed she was admitted on [DATE] with diagnoses including anemia, dementia, and anxiety disorders. Review of Resident #32's Minimum Data Set (MDS) Section C, Cognitive Patterns, showed her Brief Interview for Mental Status (BIMS) score was not completed. Section C did note Resident #32 was severely impaired cognitively. An interview was conducted on 6/12/24 at 4:30 p.m. with Staff X, Licensed Practical Nurse (LPN)/Unit Manager (UM). She was observed going to Resident #32's room and looking at her arm bands. Staff X said she would have taken the arms bands off if she had seen them. She said she could also see a concern with them being irritating to the resident's skin. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 6/12/24 at 4:38 p.m. with the DON. When notified Resident #32 had 6 wrist bands from the hospital still on her arms after being in the facility three weeks, she agreed it was a concern and said the bands should have been removed on admission. She said they would be removed immediately. On 6/12/24 at 5:06 p.m. the DON said the facility did not have a policy on Dignity. Review of the [NAME] of Rights for resident of nursing homes posted on the facility wall showed: You, as a long-term care resident, have the right to: -Be treated courteously, fairly, and with the fullest measure of dignity.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observation, interview, and record review, the facility failed to ensure the resident had use of personal belongings for one (Resident #43) of five residents reviewed for personal property. Findings included: During an observation and interview on 06/09/24 at 10:20 a.m., Resident #43 stated she had been readmitted to the facility following a recent hospitalization . The resident stated she had been at the facility for 2 days and did not have her personal belongings. The resident was observed wearing a hospital gown. She stated she did not have her clothes. She stated she had asked staff, and everyone said, Okay, but they did not bring her clothes. The resident stated at her previous room she had all her personal items, stuffed animals and family pictures. She stated she had an air mattress to relief pressure because of wounds. She stated she had fall mats following previous falls. The resident said, most importantly, my glasses are missing. I cannot see without them. I have been asking staff for 2 days. Review of the Admission Record revealed Resident #43 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #43's Annual Minimum Data Set (MDS), dated [DATE], revealed in Section C-Cognitive and Patterns a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. An interview on 06/09/24 at 10:20 a.m. with Staff I, Licensed Practical Nurse (LPN), revealed she did not know Resident #43 did not have her personal belongings. She stated she had not noticed. She stated Staff F, Registered Nurse went to look for the fall mats. An interview on 06/09/24 at 1:48 p.m. with Staff E, Certified Nursing Assistant (CNA) revealed they were still looking for the resident's glasses. He confirmed the resident did not have an air mattress at this time. He stated these items should be in the resident's old room. He stated he did not know why the resident did not go back to that room. On 06/10/24 at 1:42 p.m., an interview was conducted with Resident #43. She stated her daughter had brought her an old pair of glasses. She stated she still had not heard from the facility regarding her other pair of glasses. She stated an aide brought her clothes this morning. The resident stated the facility had misplaced her glasses and she still did not have her air mattress. An interview on 06/10/24 at 1:58 p.m. with Staff K, Therapy assistant revealed on-going concerns post hospitalization . She stated if a resident returned from the hospital within a short period, they should normally resume the current care plan. She stated fall mats should be replaced. She stated if a resident was using pressure relieving mattress it should be provided upon return. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 06/10/24 at 2:19 p.m. was conducted with the Assistant Social Services Director (ASSD) and Regional SSD. The ASSD stated the process was to box a resident's items and inventory them accordingly when they were transferred out. She stated when a resident is readmitted , they should receive their personal items right away. They should be placed in the room as soon as the resident was admitted , if not prior to their arrival. An interview was conducted on 06/10/24 at 3:52 p.m. with the Director of Nursing (DON) and the Nursing Home Administrator (NHA). The NHA stated when a resident was admitted to the hospital, they packed the resident's room up. She stated they inventory the resident's belongings and store them in a locked area. She stated once they knew the resident was coming back or had readmitted , the CNA should go to the storage room and retrieve the belongings. She stated she did not know why Resident #43 did not receive her personal belongings. She stated they had recently hired a concierge to help assist with admissions. The DON stated upon readmission a nurse should assess the resident and if they were still at risk for falls, the fall mats should be placed in the room per orders. She stated for air mattresses, it was tricky because some residents did not own these items. She stated they would contact DME (Durable Medical Equipment) to obtain the equipment as soon as orders were in place An interview on 06/11/24 at 5:01 p.m. with the SSD revealed they were still looking for the resident's glasses. He stated they had called the hospital, and the glasses could not be found. He stated he had added her to the list to be seen the next time the physician was at the facility. Review of a document titled, INVENTORY OF PERSONAL EFFECTS, showed on discharge/move-out, personal items are sent with resident/patient or picked up responsible party. Upon transfer, personal items are to be boxed and placed in designated storage area for safe keeping (or handling per facility/community/center policy). Review of a facility policy and procedure titled, Personal Property - loss or theft, dated 07/24/17 showed the center has a process to minimize the risk of loss or theft of patient's personal property.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438 Based on interview and record review, the facility failed to ensure the grievance policy was followed to include documentation, resolution, and follow-up for 11 of 13 residents attending the resident council meeting and seven (#40, #70, #59, #39, #58, #25, and #97) of 61 total residents sampled. Findings included: Review of the facility's policy and procedures titled Complaint/Grievance with an effective date of 11/30/2014 and a revised date of 10/24/2022, revealed: Policy - The center will support each resident's right to voice a complaint/grievance without fear of discrimination or reprisal. The center will make prompt efforts to resolve the complaint/grievance and informed the resident of progress towards resolution. Procedure: 1. An employee receiving a complaint/grievance from a resident, family member and/or visitor will initiate a complaint/grievance form. * Complaint/grievance forms will be available 24 hours per day seven days a week in an unsecured common area. *Accommodations will be made to ensure residents have the opportunity regardless of their physical abilities or limitations. 2. Original grievance forms are then submitted to the grievance officer/designee for further action. 3. The grievance officer/designee shall act on the grievance and begin follow up of the concern or submit it to the appropriate department director for follow up. 4. The grievance follow-up should be completed in a reasonable time frame; This should not exceed 14 days. 5. The findings of the grievance shall be recorded on the complaint/grievance form. 6. The results will be forwarded to the executive director for review and filing. 7. The grievance official will log complaints/grievances and monthly grievance log. 8. The individual voicing the grievance will receive follow up communication with the resolution, a copy of the grievance resolution will be provided to the resident upon request. 1. During a Resident Council (RC) Meeting on 06/10/24 at 3:15 p.m., residents voiced the following concerns: 11 of 13 residents present stated they had an unresolved grievance about frequently receiving their meals cold for months. The residents stated they were told the facility was going to get tray warmers but the food continued to be cold. Ten of thirteen residents present at the meeting voiced dissatisfaction with the dietary service offered by the facility. Resident #40 stated residents could report a grievance and the facility accepted the grievance, but the breakdown in the process was a resolution. There was never a resolution. Resident #70 stated the facility used to provide the resident with a copy of the grievance when they placed grievances, but we are no longer allowed to have a copy of the grievance we complete. I asked for a copy of a grievance I wrote and was told no. The facility starts to take steps to correct the grievance but generally fall short. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/09/24 at 11:34 a.m. with Resident #59 revealed the food was always cold and had informed the facility of this concern. A review of the Admission Record for Resident #59 revealed she had resided in the facility for over 5 years. Review of Resident #59's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status score of 15 out of 15, indicating intact cognition. Review of the Grievance Log revealed: Resident #39 filed a grievance on 05/24/24 related to cold breakfast. The findings of the investigation showed the hot pellet warmer had not been working for a long period of time. Maintenance had been working to fix it. The plan to resolve the complaint/grievance indicated waiting for the hot pellet warmer to be fixed. The expected results of action taken was to fix the pellet warmer. The post investigation follow up showed the resident understood the pellet warmer was down right now, and staff would try to pass trays out in a timely manner. Resident was understanding and would keep her updated during guardian angel rounds. Resident #58 filed a grievance on 05/24/24 related to cold food. The findings of the investigation showed the hot pellet warmer had not been working for a long period of time. Maintenance had been working to fix it. The post investigation follow up documented explained to the resident the pellet warmer was down and maintenance was fixing it. Resident was understanding and would keep her updated during guardian angel rounds. Resident #25 filed a grievance on 05/29/24 related to cold food. The findings of the investigation showed the hot plates were used with hot food. The plan to resolve the issue was to ensure meals were sent to the floor timely. A review of the Resident Council Meeting Minutes from 01/02/24 to 05/31/24 showed no concerns related to cold food; however, a grievance filed by the Resident Council on 05/24/24 related to cold food. The findings of the investigation showed the hot pellet warmer had not been working properly and maintenance was aware of the situation. A steam table was approved and when it comes, staff will put in place. Residents were thankful that the facility was working on a steam table to ensure meals were hot. Review of the Food Committee Meeting Minutes dated 01/05/24 showed there was a concern about cold food. The pellet warmer was not working. Review of the Food Committee Meeting Minutes dated 05/24/24 showed there were concerns about cold food. On 06/12/24 at 11:53 a.m., the Kitchen Manager reported she reports concerns voiced during the Food Committee Meetings to her boss and the Administrator via email. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/12/24 at 11:59 a.m., the Kitchen Manager stated she had not been invited to the Resident Council Meetings. She sets up the meetings for the Food Committee. She reported the facility does not have food delivery carts with warmers. The Kitchen Manager stated the pellet warmer was not working, and this had been an issue prior to her being employed here. Review of the background screening log revealed the Kitchen Manager had a hire date of 4/30/2024. The pellet warmer was leaving the kitchen today stated the Kitchen Manager. She had done audits on food temperatures, and she found that the Certified Nursing Assistants (CNAs) were not delivering the trays timely. There had been some education done. On 06/12/24 at 10:19 a.m., the Social Services Director (SSD) reported anyone can write a grievance. When he receives a grievance related to dietary, he makes a copy of the grievance, put it on the Grievance/Concern Log, and takes the grievance to the Kitchen Manager. The Kitchen Manager conducts the investigation. After the investigation was complete, he would close it out and follow up with the resident and make sure the resident signs the grievance. The SSD reported he had received a lot of dietary grievances related to cold food. Dietary has been a trend, stated the SSD. The SSD stated there had been issues with cold food because they had to order a part for a piece of equipment. On 06/12/24 at 11:05 a.m., the Administrator stated she hadn't heard any concerns regarding cold food since the last grievance was received on 05/24/24. The resolution was more so explaining to the residents what was going on with the pellet warmer in the kitchen. The wire was not functioning properly. It was fixed but went down again, and they had to order another part. She stated right now it does not get super-hot. On 06/12/24 at 11:48 a.m., the Administrator reported the pellet warmer had been fixed before and provided documents related to the work orders. -An invoice dated 01/26/24 showed the plate warmer was not working. Replaced the high limit and thermostat. tested the unit for proper operation and unit was working properly. -An invoice dated 03/22/24 showed 2 or 3 bins on the plate warmer not heating. They took the plates out and checked all wires, adjusted the thermostat, and then tested the unit for proper operation. -An invoice dated 05/15/24 showed the hot food steam table had power issues. The technician arrived onsite and determined parts needed, however the unit was made in 1998 and parts are obsolete, provider was recommending replacement as they cannot locate parts. -An invoice dated 06/06/24 showed pending work was in progress for the pellet warmer to replace 20 dispenser springs, replace thermostat, and replace high limit. The replacements had not been approved. 2. During an interview on 6/12/2024 at 9:09 AM, Resident #40 stated he was having concerns regarding missing clothing and a broken TV since returning from the hospital in April 2024. The resident stated when he returned from his hospitalization his room had been changed and that's when he discovered the missing items and the TV was not working right. Resident #40 stated the concerns were not being followed up on, and Resident #40's responsible party contacted the Ombudsman. Resident #40 reported the Ombudsman came to the facility and spoke with him. Resident #40 stated the Ombudsman would speak with the administration and follow back up. Resident #40 has not had any further follow up. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Grievance Logs from February 2024 to current, revealed one grievance in regard to missing clothing from March, 18, 2024. No other grievances were found related to Resident #40. On 6/12/2024 at 9:43 AM, the Social Service Director (SSD) reviewed the grievance process. The SSD reported once the grievance was received, it was logged in by social services. A decision of who was responsible for investigating the grievance was made. Then the department manager was responsible to investigate, determine resolution and follow up with the resident/responsible party. Once completed, the grievance form was returned to social services. The SSD stated, we like to get them back in three to five days. The SSD stated the Administrator (NHA) and SSD meet weekly to discuss grievances. The SSD was not aware of the Ombudsman visit for Resident #40 and stated a grievance would need to be completed if the visit was related to a concern. The SSD confirmed Residents #40's only grievance on file related to missing clothing in March of 2024. Interview on 6/12/2024 at 11:04 AM with the Nursing Home Administrator (NHA) revealed she was aware of Resident #40's concerns regarding the issues with the TV and the Ombudsman visit. The NHA stated a grievance was completed but never provided any documentation of the grievance. 3. During an interview on 6/12/2024 at 9:28 AM, Resident #97 stated the facility requested he complete a room change in April of 2024. Resident #97 stated he agreed to the move and while he was at dialysis, the facility packed up his belongings and moved them to the new room. The resident reported that his good clothing that were in the closet in the previous room missing upon his return. Resident #97 stated he told the NHA his good clothing was missing. Resident #97 stated he never received any follow up in regards to the missing clothing. During an interview on 6/12/2024 at 9:43 AM with the SSD. The SSD confirmed no grievances were filed for Resident #97. 41015 48223

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on interview, record review, and review of the facility's policy Abuse, Neglect, Exploitation & Misappropriation, the facility failed to ensure protection from repeated incidents of verbal abuse by Resident #96 towards one (Resident #34) of three residents reviewed for abuse. Findings included: During an interview on 06/11/24 at 12:50 p.m., Resident #34 stated he was receiving his medications at the nursing station around 7:00 a.m. this morning with Staff A, Licensed Practical Nurse (LPN). Resident #34 stated while taking his medication Resident #96 came to the nurses station and verbally assaulted me calling me a fat ass and using the F word. Resident #34 stated Staff A Licensed Practical Nurse (LPN) heard everything and all she did was apologize to me for his behavior. Resident #34 stated Staff B Licensed Practical Nurse (LPN), Unit Manager (UM) also came to speak with him and apologized for Resident #96's behavior towards him. Resident #34 stated this was not the first time this had occurred and he was getting tired of everyone always apologizing for Resident #96's behavior and not doing anything about it. Resident #34 stated everyone told me to just stay away from him but Resident #96 was the one who seeks me out most of the time and these verbal attacks on me need to stop. Review of the Admission Record showed Resident #34 was admitted to the facility on [DATE] with diagnoses that included but not limited to Unspecified Sequela of unspecified Cerebrovascular disease, recurrent depressive disorder, difficulty walking, weakness, type II diabetes mellitus and osteoarthritis. The quarterly Minimum Data Set (MDS) dated [DATE], Section-C-Cognitive Patterns showed Resident #34 had a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. Review of the Admission Record showed Resident #96 was admitted to the facility on [DATE] with diagnoses that included but not limited to Schizophrenia, Encephalopathy, difficulty walking, pancytopenia, alcohol abuse uncomplicated and muscle weakness. Review of the the quarterly MDS dated [DATE], Section-C-Cognitive Patterns showed Resident #96 had a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. During an interview on 06/11/24 at 12:58 p.m., Staff A Licensed Practical Nurse (LPN) stated there was a verbal altercation between Resident #34 and Resident #96 this morning. Staff A LPN stated Resident #34 was at the medication cart getting his blood pressure taken when Resident #96 approached the nurses station and began cussing at Resident #34. Staff A LPN stated that Resident #34 did not engage in the verbal altercation and Staff B LPN, Unit Manager (UM) heard Resident #96 yelling and came out of her office and took care of the issue. Staff A LPN confirmed this was not the first encounter between Resident #34 and Resident #96 and stated they have a history and did not like each other. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/24 at 1:01 p.m., Staff B LPN,UM stated she heard an altercation this morning and came out of her office to see what was going on. Staff B LPN, UM stated she was aware of Resident #96's mental health issues, so she immediately went out the verbal altercation and told Resident #96 to cut it out and told Resident #96 to take a walk. Staff B LPN, UM stated Resident #96 then walked down the hall allowing separation between both Resident #34 and #96. Staff B LPN, UM stated Resident #34 and Resident #96 did not like it each other. During an interview on 06/11/24 at 1:08 p.m., the Administrator stated she was also the Risk Manager. The Administrator stated that nothing had been reported regarding any abuse or resident to resident altercation today. The Administrator stated that she had heard nothing about the verbal altercation between Resident #96 and Resident #34 from this morning, 06/11/2024. The Administrator stated if a Resident to Resident altercation occurred she would have expected Staff B LPN, UM to have reported it to her right away so she could have filed a report within the appropriate timeframe and per policy. The Administrator stated that she would report this altercation immediately and start an investigation now. During an interview on 06/11/24 at 1:12 p.m., Resident #96 stated that he did not like Resident #34 and he did tell him off. Resident #96 stated that Resident #34 was also trying to mess with his life and get him in trouble. Review of the facility's policy Abuse, Neglect, Exploitation & Misappropriation revised date 11/16/22 showed, Verbal Abuse may be considered a form of mental abuse. Verbal abuse includes the use of oral, written or gestured communication, or sounds, to resident within hearing distance regardless of age ability to comprehend or disability. 7. Reporting/Response: Any employee or contracted service provider who witnessed or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown sources misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later then 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to the other officials in accordance with State law.

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	106116	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Bryan Dairy	9035 Bryan Dairy Rd Largo, FL 33777

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438 Based on record review and interviews, the facility failed to notify the resident and/or resident representative in writing of the transfer/discharge and reason and send a copy of the notice to the State Long Term Care Ombudsman's Office for three (#177, #280, and #427) of four residents reviewed for hospitalization . Findings included: 1. A review of the Admission Record showed Resident #177 was admitted to the facility on [DATE]. A review of a change in condition form revealed she was transferred to the hospital on 02/11/24 for altered mental status and did not return to the facility. Review of the medical record revealed no 'Nursing Home Transfer and Discharge Notice could be located and no documentation to indicate the Ombudsman was notified of the transfer/discharge. On 06/11/24 at 5:48 p.m., the Administrator confirmed they could not find any documentation to show the Ombudsman was notified of the discharge, and they did not have the Nursing Home Transfer and Discharge Form. 43453 2. Review of the Admission Record for Resident #280 revealed an original admitted [DATE]. Review of the contact information section revealed the resident was his own Responsible Party. The resident had an emergency contact listed. Review of a document titled, NURSING HOME TRANSFER AND DISCHARGE NOTICE, signed on 05/23/24 showed the resident was transferred to a local medical center. The reason for Discharge or Transfer was not completed. The notice section showed the form was presented by a staff member and dated 05/23/24. The area to list the Resident or Representative's name was blank. The signature line/date for the Resident or Representative to acknowledge the document was received line was blank. The area to date that the notice was provided to the Local Long Term Care Ombudsman Council was blank. Review of a document titled, NURSING HOME TRANSFER AND DISCHARGE NOTICE, signed on 05/18/24 showed the resident was transferred to a local medical center. The notice section showed the form was presented by a staff member and dated 05/18/24. The area to list the Resident or Representative's name was blank. The signature line/date for the Resident or Representative to acknowledge the document was received line was blank. The area to date that the notice was provided to the Local Long Term Care Ombudsman Council was blank. 3. Review of the Admission Record for Resident #427 revealed an original admitted [DATE]. A review of a change in condition form revealed Resident #427 was transferred to the hospital on 03/03/24 and did not return. Review of the contact information section of the Admission Record revealed the resident was his own Responsible Party. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Nursing Home Transfer and Discharge Notice could not be located and no documentation could be found to show the Ombudsman was notified of the transfer/discharge. The record did not show any discharge paperwork was provided to the resident. On 06/11/24 at 11:31 a.m., the Assistant Social Services Director (ASSD) reviewed Resident #427's medical record. The ASSD could not locate the transfer forms in the record. She stated upon discharge all paperwork should be filed in the resident's chart. She stated the expectation was for the nurse who was sending the resident out to initiate the paperwork. She stated if the resident was their own person they would sign, and if the resident was not able to sign, the nurse will write unable to sign and send a copy with the resident to the hospital. If a responsible party was notified of the transfer, it should be documented notification was conducted via phone. An interview was conducted on 06/11/24 at 1:35 p.m. with the Social Services Director (SSD), Regional SSD, and the Nursing Home Administrator (NHA). The Regional SSD confirmed the records she reviewed for Resident #280 and #427 did not show the resident/representative were notified of the transfers. The Regional SSD confirmed the Nursing Home Transfer and Discharge Notices for the two Nursing Home Transfer and Discharge Notices for Resident #280 were incomplete. The SSD confirmed it should be documented if the residents were unable to sign. The SSD stated she faxes the notifications of transfer/discharge to the Ombudsman. She stated if the Ombudsman was notified, it should be documented. The NHA stated they should be keeping a fax as evidence the ombudsman was notified. Review of a facility policy and procedure document titled, Transfer/Discharge Notification and Right to Appeal, Revised 10/14/22, showed transfer and discharges of residents, initiated by the center (facility initiated) will be conducted according to federal and/or state regulatory. When the center transfers or discharges a resident under any of the circumstances listed above [emergency transfers to acute care], the facility will ensure that the transfer or discharge is documented in the residents medical record and appropriate information is communicated to the receiving healthcare institution or provider. Review of Notice before transfer showed: Before a center transfers or discharges a resident, the center must: Notify the resident and resident representative of the transfer or discharge and the reasons for the move in writing (in a language and manner they understand). The center must send a copy of the notice to a representative of the office of the state Long-Term Care Ombudsman. Record the reasons for the transfer or discharge in the resident's medical record. Notice must be made as soon as practicable before transfer or discharge.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on record review, staff interviews, and review of the facility's policy titled Resident Assessment-Coordination with PASARR Program, the facility failed to complete the Level II Preadmission Screening and Resident Review (PASARR) documentation for one (#118) of six residents sampled for PASARRs. Findings included: Review of the admission record for Resident #118 revealed an admitted [DATE] with diagnoses of Alzheimer's disease, primary, depression, and unspecified mood affective disorder. Review of the medical record showed a Level I PASARR was not conducted upon admission. Review showed it was initiated on 05/26/24. Review of Resident #118's Level I PASARR dated 05/26/24 showed diagnoses of Depressive Disorder, other Mood Disorder and Alzheimer's Disease were indicated. The Level I PASARR showed the resident had exhibited behaviors that made them a danger to themselves or others. Level II evaluation section showed Resident #118 had documented behavioral observations, has interpersonal functioning problems, concentration persistence and pace problems, and difficulty adapting to change. On 06/10/24 a level II PASARR was initiated. The requested documents were not submitted. On 06/11/24 at 2:40 p.m., the Regional Social Services Director (SSD) stated she had just submitted the Level II documentation today. She said, I cannot speak of the timing. I don't know why it had not been submitted. She stated nursing should have submitted the paperwork for the Level II recommendation. An interview was conducted with the Director of Nursing (DON) on 06/11/24 at 3:48 p.m. She stated she had initiated the Level I PASARR on 05/26/24. She confirmed Resident #118 did not have a level I PASARR in place upon admission. She said, I have been the only one reviewing PASARRs. Admissions should have initiated a Level I prior to admission or upon admission. She stated upon review of the Level I, she initiated the Level II, but did not submit the required paperwork. She stated she was the only one catching up on PASARRs at that time. She stated the Social Services Department did not have qualified personnel, but they do now. Review of a facility policy titled, Preadmission Screening and Resident Review, dated 11/08/2021, showed The center will assure that all Serious Mentally Ill (SMI) and Intellectually Disabled (ID) residents receive appropriate pre-admission screenings according to the Federal/State guidelines. The purpose is to ensure that the residents with SMI or are [sic] ID receive the care and services they need in the most appropriate setting.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on record review, interview, and review of the facility's policy, the facility failed to ensure residents received an accurate Level I Preadmission Screening and Resident Review (PASARR) for four (Residents #20, #36, #42, and #96) of six residents reviewed for PASARR. Findings included: 1. Review of the Admission Record showed Resident #20 was initially admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, schizophrenia and mixed anxiety disorder. Review of Resident #20's PASARR dated 01/15/24 Section A. MI or suspected MI (check all that apply) showed the check boxes next to Anxiety Disorder and Schizophrenia were not marked. 2. Review of the Admission Record showed Resident #96 was initially admitted to the facility on [DATE] with diagnoses that included schizophrenia unspecified, other seizures and alcohol abuse, uncomplicated. Review of Resident #96's PASARR dated 12/22/23 Section A. MI or suspected MI (check all that apply) showed the check boxes next to Schizophrenia and Substance Abuse were not marked. On 06/11/24 at 3:35 p.m., the Director of Nursing (DON) stated she had been working in the facility for two months. The DON stated when she was first hired there was no one in the facility to review PASARRs. The DON stated that the facility had identified PASARRs that were incorrect and there was a list of PASARRs that need to be corrected, but she was the only person completing this task. The DON stated she would continue to work on them when she could. 39438 3. A review of the Admission Record showed Resident #36 was initially admitted to the facility on [DATE] with a Principle/Primary diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Section I- Active Diagnoses of the Minimum Data Set (MDS) dated [DATE] showed the resident had diagnoses of non-Alzheimer's Dementia, anxiety disorder, depression, and schizophrenia. Review of Resident #36's PASARR dated 08/28/18 showed the resident was marked no for a primary diagnosis of Dementia. 4. A review of the Admission Record showed Resident #42 was initially admitted to the facility on [DATE] with diagnoses present on admission to include bipolar disorder, major depressive disorder, and post-traumatic stress disorder. An additional diagnosis of anxiety disorder, unspecified with an onset date of 10/12/2023 was also listed. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section I- Active Diagnoses of the MDS dated [DATE] showed diagnoses of anxiety disorder, depression, bipolar disorder, and post-traumatic stress disorder (PTSD). Review of the PASARR dated 05/25/23 showed the resident had diagnoses of bipolar disorder and PTSD. The resident's PASARR was not updated to reflect the new anxiety diagnosis that occurred during the resident's stay. On 06/11/24 at 5:27 p.m., the Director of Nursing (DON) stated she would expect to see all the diagnoses listed on the PASARR and if a resident had a primary diagnosis of dementia, a Level II should be completed.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 46234 Based on observation, interview, and record review, the facility failed to ensure Activities of Daily Living (ADLs) were appropriately provided for two (Residents #32, and #68) of five residents sampled for ADLs. Findings included: 1. An observation and interview was conducted on 6/10/24 at 11:27 a.m. with Resident #32. She was observed in a hospital style gown with hospital arm bands on her wrist. The resident said she did not get showers, and no one got her out of bed. Review of the Admission Record for Resident #32 showed she was readmitted on [DATE] with diagnoses including anemia, dementia, morbid obesity, overactive bladder, and anxiety disorders. Review of Resident #32's Minimum Data Set (MDS) Section C, Cognitive Patterns, showed her Brief Interview for Mental Status (BIMS) score was not completed. Section C did note Resident #32 was severely cognitively impaired. Review of Resident #32's task documentation by the Certified Nursing Assistants (CNAs) showed the resident had two showers (6/3 and 6/10/24) and two bed baths (5/30 and 6/6/24) since her re-admission on 5/22/24. Although documentation showed Resident #32 had a shower on 6/10/24 at 1:28 p.m., the resident was observed to be in the same hospital style gown on 6/10/24 at 3:34 p.m. An interview was conducted on 6/10/24 at 3:34 p.m. with Resident #32. The resident said she had not been out of bed all day and had not showered. An interview and observation was conducted on 6/10/24 at 3:37 p.m. with Staff Y, Registered Nurse (RN). She was observed going to Resident #32's room and looking at the resident. She said the resident had been in the same gown all day. She was observed checking the daily shower sheets and said she had not received one for Resident #32. She said the CNAs should document under tasks and fill out a shower sheet when they gave a resident a shower or bed bath. Staff Y reviewed Resident #32's task documentation and confirmed it showed the resident was scheduled for showers on Monday and Thursday on the 7:00 a.m. to 3:00 p.m. shift and a shower had been documented as done that day. She said additional shower sheets would be in the Unit Manager's office. On 6/12/24 Staff X, Licensed Practical Nurse (LPN)/Unit Manager (UM) provided all the shower sheets she had for Resident #32. The only shower sheet since the resident was readmitted was on 5/28/24. That shower sheet showed the resident had a shower and noted redness to the pubic area. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #32 was observed to remain in the same position in bed with the same gown on throughout the days of 6/10 and 6/11/24. An interview was conducted on 6/11/24 at 11:55 a.m. with Staff W, RN. She confirmed she provided wound care to residents. She said Resident #32 did not currently have any wounds but did have redness and irritation on her buttocks and was getting zinc barrier cream applied. 2. An interview was conducted on 6/9/24 at 4:21 p.m. with Resident #68. She said she did not get showers, she said she only got cleaned up. She said it took at least 30 minutes to get cleaned up after she pushed her call light, then staff came in with an attitude. Review of Admission Records showed Resident #68 was readmitted on [DATE] with diagnoses including sepsis due to Methicillin Resistant Staphylococcus Aureus (MRSA), fracture of right patella, depression, and anxiety. Review of Resident #68's MDS, Section C, Cognitive Patterns, showed her BIMS score was a 15, which indicated she was cognitively intact. Review of Resident #68's care plan for ADL care showed she required an assist of one staff member for bathing/showering. Review of Resident #68's task documentation by the CNAs showed the resident had five showers (5/30, 6/1, 6/2, 6/9, and 6/11/24) and seven bed baths (6/3, 6/4, 6/5, 6/6, 6/7, 6/8, and 6/9/24) in the past two weeks. On 6/12/24 Staff X, LPN/UM was unable to provide any shower sheets for Resident #68. She said she did not know why there were not any. A follow-up interview was conducted on 6/12/24 at 3:14 p.m. with Resident #68. The resident said she absolutely did not have showers on 6/9 and 6/11/24. She said she had not even had a good bed bath in weeks. She said the only thing that was done was that her private area was cleaned up when her brief was soiled. She said not even her back had been washed. An interview was conducted on 6/12/24 at 3:42 p.m. with the Staffing Coordinator. She said she was also a CNA and worked shifts on the floor. She said resident showers were always documented in tasks and a shower sheet was filled out. She said CNAs should only document what they did. An interview was conducted on 6/12/24 at 3:47 p.m. with Staff X, LPN/UM. She said call lights should be answered and briefs changed immediately if needed. She said showers should be documented by CNAs in tasks and on a shower sheet. She said a shower should absolutely not be documented if it was not done. An interview was conducted on 6/12/24 at 4:38 p.m. with the Director of Nursing (DON). The DON said she would expect a resident to receive a shower if they wanted one. She said it was not up to the CNAs to decide if a resident got a shower or bed bath. The DON said a shower should be documented under tasks in the medical record if and only if a resident received the shower, and a shower sheet should be filled out. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at 5:06 p.m. the DON said the facility did not have a policy on ADLs or Showers.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observation, interview, and record review, the facility did not ensure residents unable to carry out ADL (Activities of Daily Living) received assistance related to hair care for one (Resident #117) of five residents reviewed for ADLs. Findings included: An observation and interview was conducted on 06/09/24 at 2:14 p.m. with Resident #117. The resident was observed with matted, tangled clumps of hair. She stated she had asked staff for help. She said, I need help with my hair. The staff are not available to help. They are too busy. There is not enough time for me. It will take time to untangle. No one has the time. The resident stated she had been begging staff to help her with her hair since admission. She stated she did not like looking like a bird's nest. She said, it is embarrassing. I would like to brush my hair again. Review of the Admission Record for Resident #117 showed an admitted [DATE], with diagnoses to include partial traumatic metacarpophalangeal amputation of unspecified finger and need for assistance with personal care. Review of Resident #117's Admission Minimum Data Set (MDS), dated [DATE], in Section C-Cognitive and Patterns, showed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. On 06/11/24 at 02:45 p.m., Resident #117 stated a CNA was supposed to help her last night. She never came back this happened all the time. The Resident said, I have not washed my hair since I was admitted because if I wash it, it will be stinky because it will not dry. It is already matted. The resident stated she had been at this facility for almost 2 months. Review of a care plan with a focus ADL-self-care, dated 04/25/24 showed the resident had a self- care deficit related to activity intolerance, fatigue, impaired balance, limited mobility, and trauma to Right hand. Interventions for personal hygiene, bathing/showering showed the resident required assistance by staff for personal care and bathing/showering. An interview on 06/11/24 at 3:05 p.m. with Staff L, Certified Nursing Assistant (CNA) confirmed the resident was admitted with matted hair following a lengthy hospitalization . She stated some CNA's had started helping the resident untangle the hair. She stated, It just takes a while. I know, two months is a long time to wear your hair like that. We have to keep trying. We just don't have the time among the other duties. Staff L stated the resident would not be able to untangle the hair herself. She confirmed the resident needed staff's assistance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 06/11/24 at 3:10 p.m. with the Director of Nursing (DON). She stated she just heard about the resident with matted hair. The DON stated residents who were dependent on staff should receive care as needed. She stated they had to prioritize care. She said, We are trying. I understand it's a dignity issue. We hired a concierge two weeks ago. She spent an hour helping her. The DON stated there was only so much they could do because the staff had to attend to higher care needs. She said, I know she is dependent. It is just not a priority for nursing staff. The DON stated the resident refuses to cut her hair. An interview on 06/11/24 at 4:34 p.m. with the Nursing Home Administrator (NHA) revealed they did not have someone to do hair. She stated they had a salon, but it was currently closed. She stated they had recently hired a concierge who would be helping with things like this. On 06/11/24 at 05:22 p.m., the NHA stated they did not have a policy on ADLs.

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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** 43453 Based on observation, interview, and record review, the facility failed to ensure the resident received proper treatment to maintain communication abilities for one (Resident #280) of three residents sampled. Findings included: Review of the Admission Record for Resident #280 revealed an original admitted [DATE] and a re-admitted [DATE] with diagnoses to include Deaf non-speaking. During an observation on 06/09/24 at 9:30 a.m., Resident #280 was laying on his bed staring at the Television which was turned off. The resident did not respond to the interview. The resident looked at this surveyor and initiated hand movements, signaling he communicated via sign language. A look around the room revealed there were no personal effects and there were no communication assistive devices, or anything indicating the resident required assistance to communicate with others. Review of an admission Minimum Data Set (MDS) dated [DATE] showed in section B0200 - Hearing, Speech, and Vision, the resident was highly impaired related to absence of useful hearing. B0700 showed the resident is sometimes understood and his ability to make concrete requests was limited. B0800 the resident sometimes understands others. Under B1000 - vision, the resident is highly impaired. Under Health literacy B1300, the resident always needed to have someone help him when he read . written material. Section C - Cognitive Patterns revealed a BIMS (Brief Interview for Mental Status) score of 00, meaning the resident was unable to complete the interview. Review of a care plan initiated on 04/30/24 showed Resident #280 was care planned for a communication problem related to hearing deficit/deaf and partial blindness. Interventions showed to anticipate and meet needs. Be patient with resident as he is deaf and has poor vision. Resident requires assistance with communication. Provide translator as necessary to communicate with the resident. The resident is able to communicate by gesture sign language/translator. Use ASL (American Sign Language) to communicate with patient as deemed appropriate. An interview on 06/09/24 at 9:39 a.m. with Staff D, Certified Nursing Assistant (CNA) revealed the resident was deaf. She stated the resident communicated via sign language and she communicated with him by trying to guess what he needed. She stated the resident was new to this part of the building and she was getting to know him. Staff D, CNA stated the resident stayed in his room most of the time. She stated if he was out, he watched television and did not engage easily with others due to communication disability. On 06/10/24 at 1:54 p.m., an interview was conducted with Staff E, CNA. He stated this resident was deaf. He stated he communicated with him by asking Yes, or NO questions. The CNA stated he tried to guess what the resident was trying to say. He stated he would ask the nurse if he could not figure out what the resident was saying. He stated he did not know any sign language and he was not aware if any of the staff were able to sign. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Bryan Dairy	9035 Bryan Dairy Rd Largo, FL 33777

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 06/10/24 at 2:30 p.m. with Staff G, Registered Nurse (RN) revealed she did not know much about this resident. She said, When I walked in earlier, he did not respond to me. I called out to him. His eyes were open. I walked to him and tapped his shoulder. I placed the medication cup in his hand. He knew that meant he should take his medications. Staff G stated she did not know if he was deaf. She stated the resident was new to her and she would review his care plan to know how he communicated. During this interview, this surveyor and nurse walked into the resident's room. He did not have any signs posted to let someone know his preferred method of communication. The room was noted very warm, the temperature on the unit showed it was on heat settings and a reading of 78 degrees was noted. The Nurse stated she did not know if it was the resident's preference to have the heat on during hot summer months. She said, I am not sure if this was his preference. You know there is a language barrier. The nurse attempted to interact with the resident. The resident signed back in response, which the nurse did not understand. Staff G stated she would have to find out what he was trying to say. In an interview on 06/10/24 at 2:45 p.m. with Staff H, RN/ MDS and the Regional MDS, they stated staff should know how to communicate with the resident. The Regional MDS stated the nursing staff could review the [Brand Name of a filing system used in nursing homes] to identify the resident's communication needs. She stated for other people without access, there should be a sign directing them to see nurse posted on the door. She stated they had a care plan with interventions to reach out to the resident's family member for assistance. The Regional MDS stated there should be a number to call for ASL assistance. She stated she would update the care plan to include a communication board or cards with familiar phrases. An observation on 06/11/24 at 9:14 a.m. to 06/11/24 at 12:04 p.m., revealed Resident #280 in a Broda chair positioned in front of the television in the common/dining area in hall 300. This resident was not observed participating in any activities or engaging with staff or residents. During this time period, other residents were observed participating in various activities such as puzzles, cards, making phone calls and engaging with each other and staff in conversations. Resident #280 had his back turned to the other residents the entire time. The resident was unable to initiate any interaction with staff or other residents. Review of a facility policy subject, Reasonable Accommodation of Hearing Impaired, revised 09/05/2017, showed upon admission the charge nurse will determine the level of hearing impairment. If a hearing impairment is noted staff will consult with the resident and if applicable family members to determine what auxiliary aids may be needed to ensure effective communication. If hearing impairment exists, then the following interventions may be implemented as deemed appropriate. Personnel to directly face resident when speaking to him or her. Allow resident to see facial expression to help lip reading. Provide pencil and paper to communicate in writing in cases of totally deaf. Determine residents awareness of hearing loss. Should a qualified interpreter be needed, the family should consult with social services to identify local resources.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on observation, interview, and record review, the facility failed to ensure proper care to prevent the worsening of pressure wounds for two (Residents #74 and #12) of four residents sampled for pressure wounds. Findings included: An observation was conducted on 6/11/24 at 11:48 a.m. of Resident #74 lying in bed with his legs exposed crying out for assistance. He said his feet hurt and he needed help moving his leg. The resident was observed to have bandages on both heels and his feet were propped up on a plastic pack of disposable briefs. (Photographic evidence obtained with resident permission.) An observation and interview was conducted on 6/11/24 at 11:50 a.m. of Staff V, Certified Nursing Assistant (CNA) entering Resident #74's room and assisting to reposition his leg. Staff V confirmed the resident's heels were being offloaded with a pack of briefs. She said his pressure relieving boots were in the laundry so someone must have put those there. Staff V said the resident had wound care that morning and maybe they put the briefs under his heels. Review of Admission Records showed Resident #74 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, muscle weakness and difficulty walking. The resident was listed as his own responsible party. Review of Resident #74's Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, showed the resident had a Brief Interview for Mental Status (BIMS) score of 2, indicating severely impaired cognition. Review of Resident #74's physician orders showed: -Encourage offloading bilateral heels while in bed. Every shift for unstageable bilateral heels as tolerated. Date 6/4/24. Review of wound care provider notes showed the resident had right and left heel wounds. On 5/6/24 the wound etiology was noted to be pressure, unstageable, and offloading boots were in place. On 5/15/24 the left and right heel wounds were changed to stage 4. An interview was conducted on 6/11/24 at 11:53 a.m. with Staff W, Registered Nurse (RN). She confirmed Resident #74 had stage 4 pressure wounds on both heels that were in house acquired. She said the resident had boots to offload his heels while he was in bed. Staff W reviewed the photo of Resident #74's heels propped on a pack of briefs. She said that was totally inappropriate. She said she would never put briefs under someone's feet to offload them. She said had she seen that she would have fixed it immediately and educated staff. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 6/11/24 at 12:31 p.m. with the Director of Nursing (DON). She reviewed the photo of Resident #74's heels offloaded with the pack of briefs. The DON said that was not at all appropriate and she could not believe someone would have used briefs to prop his heels on. She said it should not have happened and she would investigate. Review of the Admission Record showed Resident #12 was originally admitted to the facility on [DATE] with diagnoses that included but not limited to multiple sclerosis, restless leg syndrome, polyneuropathy, and Parkinson's disease with dyskinesia without mention of fluctuations. Review of the quarterly Minimum Data Set (MDS) dated [DATE] Section-C-Cognitive Patterns showed Resident #12 had a Brief Interview for Mental Status (BIMS) of 15 (Cognitively Intact). Review of Resident #12's care plan showed a focus [Resident #12] has a pressure injury to the right heel. The goal showed, The resident's pressure injury will show signs of healing and have minimal risk of infection by/through the review date. The interventions included but not limited to: Administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing, and monitor dressing to ensure it is intact and adhering report loose dressing to the nurse An additional focus showed, [Resident #12] has an arterial ulcers to: left dorsal 2nd toe, left lateral malleous, left dorsal 3rd toe, left lateral foot and left dorsal 4th toe. The goal showed, The resident will be free from infection or complications related to arterial ulcer through review date. The interventions included but not limited to Monitor/document wound document progress in wound healing on an ongoing basis, wound medical doctor visit at [local] medical weekly as ordered, WOUND/DRESSING change the dressing and record observations of site. Review of Resident #12's current orders showed wound care orders as followed: - Consultation with wound care provider dated 06/01/24 - Consult with Wound Care [as needed] PRN dated 05/06/24 - [Brand name for a strong topic antiseptic] (1/4 strength) External Solution 0.125% (Sodium Hypochlorite) - Apply to left dorsal 2nd toe topically as needed for unstageable if soiled dated 05/06/24. - [Brand name for a strong topic antiseptic] (1/4 strength) External Solution 0.125% (Sodium Hypochlorite) - Apply to left dorsal 3rd toe topically every day shift for unstageable. Use [Brand name for a strong topic antiseptic] Solution, wet gauze, and apply to wound bed for 10 mins prior to dressing application, use wound cleanser, pat dry, apply Aquacel AG hydrofiber cleanser with silver (cut to size of wound bed as directed), apply ABD Pad, cover with kerlix dated 05/06/24. - [Brand name for a strong topic antiseptic] (1/4 strength) External Solution 0.125% (Sodium Hypochlorite) - Apply to left dorsal 4th toe topically as needed for unstageable if soiled dated 05/06/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- [Brand name for a strong topic antiseptic] (1/4 strength) External Solution 0.125% (Sodium Hypochlorite) - Apply to left dorsal 4th toe topically every day shift for unstageable. Use [Brand name for a strong topic antiseptic] Solution, wet gauze, and apply to wound bed for 10 mins prior to dressing application, use wound cleanser, pat dry, apply Aquacel AG hydrofiber cleanser with silver (cut to size of wound bed as directed), apply ABD Pad, cover with kerlix. dated 05/06/24. - [Brand name for a strong topic antiseptic] (1/4 strength) External Solution 0.125% (Sodium Hypochlorite) - Apply to left dorsal 2nd toe topically every day shift for unstageable. Use [Brand name for a strong topic antiseptic] Solution, wet gauze, and apply to wound bed for 10 mins prior to dressing application, use wound cleanser, pat dry, apply Aquacel AG hydrofiber cleanser with silver (cut to size of wound bed as directed), apply ABD Pad, cover with kerlix. dated 05/06/24. - [Brand name for a strong topic antiseptic] (1/4 strength) External Solution 0.125% (Sodium Hypochlorite) - Apply to left lateral foot topically as needed for unstageable if soiled dated 05/06/24. - [Brand name for a strong topic antiseptic] (1/4 strength) External Solution 0.125% (Sodium Hypochlorite) - Apply to left lateral malleous every day shift for unstageable. Use [Brand name for a strong topic antiseptic] Solution, wet gauze, and apply to wound bed for 10 mins prior to dressing application, use wound cleanser, pat dry, apply Aquacel AG hydrofiber cleanser with silver (cut to size of wound bed as directed), apply ABD Pad, cover with kerlix. dated 05/06/24. - [Brand name for a strong topic antiseptic] (1/4 strength) External Solution 0.125% (Sodium Hypochlorite) - Apply to left lateral malleous topically as needed for unstageable if soiled dated 05/06/24. - [Brand name for a strong topic antiseptic] (1/4 strength) External Solution 0.125% (Sodium Hypochlorite) - Apply to right medial calcareous topically as needed for unstageable if soiled dated 05/06/24. - [Brand name for a strong topic antiseptic] (1/4 strength) External Solution 0.125% (Sodium Hypochlorite) - Apply to right medial calcareous every day shift for unstageable. Use [Brand name for a strong topic antiseptic] Solution, wet gauze, and apply to wound bed for 10 mins prior to dressing application, use wound cleanser, pat dry, apply Aquacel AG hydrofiber cleanser with silver (cut to size of wound bed as directed), apply ABD Pad, cover with kerlix. dated 05/06/24. Review of the Treatment Administration Record dated May 2024 showed Resident #12 missed wound treatments on the following dates: - 05/12/24 -05/14/24 -05/17/24 -05/19/24 -05/21/24 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-05/23/24 -05/24/24 -05/27/24 -05/30/24 -05/31/24 Review of the Treatment Administration Record dated June 2024 showed Resident #12 missed wound treatments on the following dates: - 06/08/24 -06/09/24 During an interview on 06/11/24 at 12:32 p.m., the Director of Nursing (DON) stated the TAR did look like the wound treatments were not completed but needed to look into this more because she wondered if it was more of a documentation error than the nurses not providing wound treatment. During an interview on 06/11/24 at 12:40 p.m., Resident #12 stated that no one provided wound treatment to her feet this weekend. Resident #12 stated that she went to the wound care clinic every Wednesday but the nurses at the facility were to provide wound care to her all other days. During an interview on 06/11/24 at 5:50 p.m., The Director of Nursing (DON) stated that she spoke with some of her nurses and they informed her the wound treatment was completed they just forgot to document they completed the treatment. The DON stated that she would have expected the nursing staff to document when they provided the wound treatment for Resident #12 but did not. Review of the facility's policy Non-pressure skin Condition Record revision date 04/01/17 showed, Policy: To document the presence of skin impairments/new skin not related to pressure when first observed and weekly thereafter. This includes skin tears, surgical sites, etc. One site will be recorded per page. Review of the facility's policy Clinical Guidelines Skin & Wound effective date 04/01/2017 showed, To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/prevention of pressure injury. Review of the facility's policy Physician Orders revision date 03/03/21 showed, Policy: The center will ensure that Physician orders are appropriately and timely documented in the medical record. Review of the facility's policy Pressure Injury Record revision date 04/01/2017 showed, Policy: To document the presence of skin impairment/new skin impairment related to pressure when first observed and weekly thereafter until the site is resolved. Once site will be recorded per page. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Clinical Nurse 1 LPN Job Description showed Duties and Responsibilities that included but not limited to 6. Comply with evaluation, treatment, and documentation of the company guidelines. 7. Complete required documentation in an accurate and timely manner. Review of the facility's Clinical Nurse 1 RN Job Description showed Duties and Responsibilities that included but not limited to 6. Comply with evaluation, treatment, and documentation of the company guidelines. 8. Complete required documentation in an accurate and timely manner. 14. Monitor compliance with resident record documentation, as directed. 46234

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41015 Based on observation, interview, and record review, the facility failed to ensure nine residents (Residents #19, #48, #76, #79, #96 #106, #107, #117 and #279) of twenty three residents reviewed for smoking returned smoking materials to staff after the designated smoking times and when returning back from leave of absence (LOA). Findings included: On 06/09/24 at 1:00 p.m., a total of thirteen residents were observed smoking in the designated smoking area. Staff O, Concierge was observed only providing one resident their cigarettes and lighter. The twelve other residents were observed to have their cigarettes and lighters already in their possession. During an interview on 06/09/24 at approximately 1:00 p.m., Staff O, Concierge stated she only had to assist one resident during this smoke break as the other twelve residents had their cigarettes and lighters already in possession and smoked without assistance. During an interview on 06/09/24 at 1:25 p.m., Resident #117 stated she smokes. Resident #117 stated she kept her cigarettes with her at all times so no one would steal them. During an observation on 06/09/24 at 4:00 p.m., nineteen residents were observed smoking. Nine of Nineteen residents were observed to have either cigarettes, lighters or both in their possession. Observations included: - Resident #76 was observed pulling out a cigarette and in possession of the cigarette. - Resident #96 was observed pulling out a lighter from his pocket. Resident #96 was then observed taking a cigarette from Resident #76. Resident #96 then lit Resident #76's cigarette and his cigarette before Staff M, Certified Nursing Assistant (CNA) even began passing out cigarettes and lighting cigarettes for other residents waiting. - Resident #107 was observed pulling a pack of cigarettes from his pocket and smoking with the assistance of Resident #96 who lit his cigarette. - Resident #19 was observed coming out to the designated smoking area and pulled out a cigarette and lighter. - Resident #117 was observed with 2 cigarettes in hand and giving those cigarettes to Resident #107 to add to his pack of cigarettes. Resident #107 was observed adding those 2 cigarettes to the pack in his possession and put the pack back in his pocket. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident #279 received a cigarette from Resident #106. Resident #279 was holding the cigarette in his hand and Resident #106 stated, do you need a light? Resident #279 stated no I am saving it for the 9 p.m. smoke break. Resident #106 said then hide it. Resident #279 was observed putting the cigarette under his shirt and taking the cigarette back into the facility. - Resident #76 was observed throwing cigarettes down into the rocky yard decor. (Photographic evidence obtained.) During an interview on 06/09/24 at 4:30 p.m., Staff M, Certified Nursing Assistant (CNA) stated she had a great relationship with the residents who smoke. She stated she ensured she took all unused cigarettes and lighters before residents entered the facility and placed them in the lock box, per policy. Review of the facility's Resident Council Meeting notes dated 05/31/24 showed, Administration addressed Smoker's not following policy, Leave of Absent Policy Issues and Actions: Administrator addressed concerns about smokers following policy. Making sure they turn in their smoking articles when they go out on LOA to purchase them and when family brings them in to turn into nurse. During an interview on 06/10/24 at 10:00 a.m., Resident #40 stated during the last Resident Council Meeting staff spoke to us regarding the smoking policy. Resident #40 stated that staff told us that they would be cracking down a lot more on residents having their cigarettes and lighters. Resident #40 said the main problem was when the residents who smoke go out on LOA and go smoke to the side of the facility under the trees and throw their cigarette butts on the dry ground. Resident #40 stated the ladies who smoke stated they put their cigarettes and lighters in their bra to keep their smoking materials. Resident #40 stated the guys who smoke put their smoking materials in their pockets or under their shirts. Resident #40 stated most of the smokers have their own stash. Resident #40 stated last night around 10:00 p.m. the nurse had to stop giving me my medications to let a smoker out the side door to smoke. Resident #40 reported the designated smoking time was 9:00-9:30 p.m. During an interview on 06/10/24 at 10:10 a.m., Resident #97 stated at the last resident council meeting the Social Services and the Activity Director stated the non-smokers do not need to worry about the smokers in the facility as staff was going to crack down on the smoking materials in the facility. Resident #97 stated it truly meant nothing because staff had been saying they were going to take control of the smoking materials for awhile now and nothing had been done. Resident #97 stated look out the window. Resident #107 was observed leaving the side of the facility where the trees were and coming back into the facility. Resident #97 stated the smokers smoke under the tree area at the side of the facility all the time. An observation of 06/10/24 at 10:23 a.m., revealed a pathway to the side of the facility with trees and bushes. Further observation showed multiple cigarette butts in this area with no proper safety equipment to dispose of cigarettes to prevent an accident hazard. The observation of the used cigarettes in this area showed multiple cigarette used butts that laid in the dry leaves and around the grass underneath the trees. Photographic evidence obtained. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/10/24 at 10:52 a.m., the Administrator stated a smoking concern had been going on since January 2024 when all the smokers walked out of the resident council meeting and refused to go back due to the smoking policy. The Administrator stated she had to call the Ombudsman to come in and talk with the Resident Council regarding resident rights for the February 2024 Resident Council Meeting. The Administrator stated residents who smoke signed themselves out on LOA and were not supposed to smoke on property. The Administrator stated those residents who go on LOA to smoke were required to go to the city sidewalk to smoke off property. The Administrator stated smokers would be required to obtain their smoking materials from the nurse prior to going on LOA and then return the smoking materials once they returned to the facility from LOA. The Administrator stated that was where the problem was as not all residents returned their smoking materials. During an interview on 06/09/24 at 12:03 p.m., the Ombudsman stated, I was invited to the facility to discuss how to set up a Resident Council Meeting and bylaws. The Ombudsman stated, I know there is a smoking concern there at the facility. The Ombudsman stated she spoke with the Administrator regarding not having control of smoking materials. The Ombudsman stated there was a resident in the facility who was concerned about smoking and his safety regarding fire. The Ombudsman stated that particular resident had a room next to the exit door because of his concern. The Ombudsman stated that resident reported residents were going outside to smoke at 2:00 a.m., and then coming back in to the facility and not turning in their smoking materials. The Ombudsman stated that resident reported there has been no change with these concerns for awhile. The Ombudsman stated she talked with the Administrator about smoking materials. The Administrator's responded, It's LOA, can't do anything about it and stated, my hands are tied. The Ombudsman stated in February 2024 the Administrator was supposed to put out a letter to residents and family that explained they can't have lighters and cigarettes in rooms or in the facility per policy and if they do break the policy then they will be issued a discharge notice. The Ombudsman stated she was unsure if that letter was ever sent out. An observation of smoking on 06/10/24 at 1:00 p.m., revealed eighteen residents smoking with four Residents who supplied their own material. - Resident #48 was observed coming out of the facility to the smoking area past the locked box of resident smoking materials and pulled out a cigarette and lighter in her possession. - Resident #96 was observed coming out of the facility to the smoking area past the locked box and pulled a pack of cigarettes out of his pocket with a lighter and began smoking without assistance. - Resident #106 was observed coming out of the facility to the smoking area and pulled a pack of cigarettes out of his pocket. Resident #106 began distributing cigarettes to Resident #6 and Resident #102. - The Administrator was outside and following around the residents smoking showing them the smoking policy. - After the smoking break, Resident #106 refused to give his pack of cigarettes to the Social Services Director (SSD) at first and re-entered the facility. Resident #106 then turned around and threw his cigarettes at the SSD and stated if even one cigarette comes up missing, he won't give them up again for staff to keep them again. (continued on next page)

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Aspire at Bryan Dairy	9035 Bryan Dairy Rd Largo, FL 33777

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 06/10/24 at 1:20 p.m., the Administrator was speaking with Resident #48 with the smoking policy in hand. Resident #48 stated to the Administrator, this is ridiculous, I can't even get my meds and your worried about my cigarettes. The Administrator continued to review the smoking policy with Resident #48. An observation on 06/10/24 at 1:35 p.m. revealed Resident #79 had a pack of cigars and a pack of cigarettes stored in the nightstand beside his bed. (Photographic evidence obtained) During an interview on 06/11/24 at 9:12 a.m., Staff N, Director of Maintenance (DOM) stated the property line ends at the white picket fence in front of the facility. The DOM stated that he came out and informed residents about smoking under the tree and educated the residents that it was a fire safety risk throwing all their cigarettes in the dry leaves and grass area, as there was a burn ban in the county. He stated that when he directed the residents to go further to the city sidewalks the residents pulled up the facility blueprint on the county website and said this land belongs to the county. Staff N, DOM stated he went to the facility's blueprints and discovered the property ends at the white picket fence. Staff N, DOM stated that he did see an accident hazard and even a fire risk with residents throwing their used cigarettes into the dry leaves and on the ground. Staff N, DOM stated it was the facility's responsibility to keep this area of land clean but it was owned by the county not the facility. Staff N, DOM stated that he would call the County Fire Department today as he was sure the county does not know the residents are throwing their used cigarettes out into the dry leaves and ground causing a fire safety risk. During an interview on 06/11/24 at 9:40 a.m., the Administrator stated that all residents are expected to follow the Smoking Policy. The Administrator stated that she gave one resident a 30 day notice yesterday for not following the policy and having smoking materials on her possession. The Administrator reviewed the photographic evidence obtained from the non designated smoking area. The Administrator confirmed residents throwing their used cigarettes down in dry grassy areas and leaves was a safety hazard. The Administrator stated maybe they could look at providing a cigarette receptacle out near that area to try to eliminate the accident hazard. An observation on 06/12/24 at 12:00 p.m., revealed Resident #79 continued to have cigars stored in the nightstand at the bedside. Review of the Smoking Agreement/Notice of Policy dated 01/2020 showed, Smoking is allowed by the Center to accommodate those who wish to smoke. However, for the safety of all residents and staff the center has promulgated a safe smoking policy. All resident who wish to smoke at the center will abide by the center's smoking policy. Resident's electing to smoke will be provided a safe smoking assessment to determine and evaluate each resident's ability to safely smoke. Because violations of the smoking policy can lead to catastrophic consequences, the smoking policy will be vigorously applied without exception. Violations of the policy will result in remedial action based upon the nature of the infraction. Remedial action includes but is not limited to to warning, revocation of smoking privilege's, police intervention, and/or discharge. The agreement represents your acknowledgement that the center has provided you a copy of the center's smoking policy and your agreement to abide by the team set forth in the policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy Smoking-Supervised revised 02/07/2020, revealed The center will provide a safe, designated smoking area for residents. For the safety of all residents the designated smoking area will be monitored by staff during the authorized smoking times. The center will have safety equipment available in designated smoking areas including: smoking blankets, smoking aprons, a fire extinguisher and non-combustible self-closing ashtrays. The center will retain and store matches, lighters, etc, for all residents. All residents who wish to smoke will sign an agreement attesting to abide by the smoking policies and procedures. Residents will be advised upon admission that violation of the smoking policy may result in revocation of smoking privileges, discharge, and/or being reported to law enforcement.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438 Based on record review and interview, the facility failed to monitor behaviors of side effects of psychotropic medications for two residents (Resident #36 and #77) out of the sampled five residents. Findings included: A review of the Admission Record showed Resident #36 was initially admitted to the facility on [DATE] with a primary diagnosis of unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and other diagnoses to include schizoaffective disorder, bipolar type, major depressive disorder, and anxiety disorder. Section I- Active Diagnoses of the Minimum Data Set (MDS) dated [DATE] showed the resident had diagnoses of non-Alzheimer's Dementia, anxiety disorder, depression, and schizophrenia. The Order Review Report dated 06/01/24-06/30/24 revealed the following orders: 02/14/24 Cymbalta Oral Capsule Delayed Release Particles 60 MG- Give 1 capsule by mouth one time a day related to major depressive disorder; 03/06/24 Risperdal Oral Tablet 0.5 MG- Give 1 tablet by mouth one time a day related to schizoaffective disorder, bipolar type 03/04/24 Seroquel Oral Tablet 200 MG- Give 200 MG by mouth at bedtime related to schizoaffective disorder, bipolar type 02/14/24 Wellbutrin XL Oral Tablet Extended Release 24 Hour 300 MG- Give 1 tablet by mouth one time a day related to major depressive disorder. The Medication Administration Record (MAR) for April, May, and June 2024 did not show behaviors and side effects were monitored for psychotropic medications. A review of the Admission Record for Resident #77 showed the resident was initially admitted to the facility on [DATE] with diagnoses to include unspecified psychosis not due to a substance or known physiological condition and major depressive disorder. Section I- Active Diagnoses of the MDS dated [DATE] showed the resident had diagnoses to include depression and psychotic disorder. The Order Summary Report with active orders as of 04/30/24 showed the following orders: 04/15/24 Amitriptyline HCL Oral Tablet 75 MG- Give 1 tablet by mouth at bedtime for depression. 04/24/24 Buspirone HCL Oral Tablet 10 MG- Give 1 tablet by mouth two times a day for anxiety. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration Record (MAR) for April, May, and June 2024 did not show behaviors and side effects were monitored for psychotropic medications. The care plan with a focus area related to anxiety initiated on 04/10/24 showed interventions to include monitor for anxiety type related behaviors and monitor for signs and symptoms of side effects from medication. The care plan with a focus area related to antidepressant medications initiated on 06/07/23 showed interventions to include monitor/document side effects and effectiveness every shift. On 06/11/24 at 5:27 p.m., the Director of Nursing (DON) stated there should be an order for behavior and side effect monitoring for psychotropic medications and it should be done per order. The policies and procedures provided by the facility Medication Management- Psychotropic Medications revised on 10/24/22 showed the following: 4. Monitor behavior and side effects every shift utilizing the Behavior Monitoring Flow Record (BMFR) or electronic equivalent.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observation, interview, and record review, the facility failed to ensure food was prepared and served at safe and appetizing temperatures for two (Resident #7 and #73) of six residents sampled for food. Findings included: During an interview on 06/09/24 at 10:38 a.m., Resident #73's family member stated he had filed grievances on her behalf related to food and care. He stated on May 5th, 2024, while he was visiting with Resident #73, the residents were served raw chicken. The family member stated a resident who was sharing the table with Resident #73 ate the whole thing. He stated he had taken a photo which he showed this surveyor, of red meat on the plate that the resident ate. He said, I told the nurse. I said if anyone gets sick, it is their fault. Review of Resident #73's Admission Record revealed she was admitted to the facility on [DATE] with diagnoses to include dementia. The record showed the family member was the Responsible Party. An interview on 06/12/24 at 11:30 a.m., revealed Resident #7 was frustrated because the food was not served at the right temperatures. Resident #7 showed this surveyor photos with dates and times when he was served raw chicken. He confirmed the dates of 05/05/24 and 06/02/24. The resident stated on 05/10/24, the residents were served grilled cheese sandwiches. He said, it was black and hard as a rock. He stated he had voiced grievances related to food, but they were never resolved. Review of Resident #7's Admission Record revealed he was admitted to the facility on [DATE]. Review of Resident #7's quarterly Minimum Data Set (MDS), dated [DATE], revealed in Section C-Cognitive and Patterns a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Review of facility menus confirmed the following: On 5/5/24 for lunch the residents were served fried chicken. On 5/10/24 for dinner the residents were served Grilled cheese sandwiches. On 6/2/24 for lunch the residents were served fried chicken. On 06/10/24 at 4:08 p.m. an interview was conducted with the facility's Certified Dietary Manager (CDM) and the Regional Dietary Manager. The CDM stated she had received grievances related to chicken being served raw. She stated a resident had shown her a photo of the raw chicken. She said, We did not serve the chicken at the right temperature. It should not have been served like that. The CDM stated in response to the incident on 05/05/24, she did an in-service. She stated the in-service was to ensure chicken was cooked until internal temperatures reached 165 degrees. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 06/12/24 at 1:53 p.m., the CDM stated she became aware there was a second incident of chicken served raw in June. She stated that was not acceptable. She said as a chef, I would know the meat closer to the bottom does not cook all the way. She stated it would be up to nursing staff to stop a vulnerable resident from eating raw meat. She stated nonetheless, it should not have gone out like that. The CDM reviewed a photo of a grilled cheese served to a resident, noted black in color. She said, yes, that is burnt. It should not have been sent out like that. She stated their expectation was to check the food temperatures after cooking, and to confirm it was thoroughly cooked prior to service. She stated the [NAME] should be utilizing a meat thermometer. She stated food should not leave the kitchen if it was not palatable. Review of a facility policy tilted, Food: Preparation, revised 02/2023, showed a policy statement that all foods are prepared with the FDA (Food and Drug Administration) Code. 10. Time/Temperature Control (TCS) hot food items will be cooked to a minimum internal temperature as follows; All poultry and stuffed foods 165 degrees Fahrenheit.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438 Based on observation, record review, and interview, the facility failed to provide food to accommodate preferences for one (Resident #59) out of six residents sampled for food. Findings included: On 06/09/24 at 11:34 a.m., Resident #59 reported the facility was no longer serving chef salads. She stated she needed to eat the chef salads because she wanted to lose weight. On 06/09/24 at 1:48 p.m., the resident was observed in the room with the meal tray in front of her. The tray consisted of mashed potatoes, green beans, and chicken broth. The resident reported she wanted to eat chef salads because she needed to lose weight. She carried a lot of weight and had pain in her back, she had diabetes, and needed to lose 40 pounds. She needed protein on her tray and was not getting any protein. She sent messages to speak with the Kitchen Manager, but she never came On 06/12/24 at 1:00 p.m., Resident #59 reported every day they gave her chicken broth, and it was too salty. They never gave her crackers with the soup. She used to get chef salads with lettuce, tomato, turkey, ham, chopped cheese, and dressing. She was told by the kitchen staff only certain people could get the chef salads. The resident asked how could she be one of the certain people. She wanted more protein and fiber for weight loss. She never got any protein. A review of the menu during the week of the survey showed chef salads were not listed on the menu. A review of the always available menu showed chef salad was not listed on the menu. A review of the meal tickets for Resident #59 showed a chef salad was not listed on the meal ticket. A review of the Admission Record for Resident #59 showed the resident was initially admitted to the facility on [DATE] with a diagnosis to include atherosclerosis heart disease of native coronary artery without angina pectoris. Section C-Cognitive Patterns of the Minimum Data Set (MDS) dated [DATE] showed Resident #59 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition. Section K-Swallowing/Nutritional Status showed the resident weighed 224 pounds. A review of the Order Summary Report with active orders as of 06/12/24 showed a regular diet, regular texture, regular/thin liquid consistency diet that started on 04/03/23. The care plan related to nutrition initiated on 08/29/19 showed a focus area to include a desire to lose weight. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/24 at 11:59 a.m., the Kitchen Manager stated she set up the meetings for the Food Committee. The residents had voiced concerns with foods that were no longer available on the always available menu such as chef salads and cold food. They had lettuce available all the time, but they did not have eggs, turkey, or ham all the time. They only had foods that were listed on the menu. The alternate meal today was chicken salad, broccoli, and she only had one order for chicken. The main course was the darker color, and the alternate was the lighter color on the menu. The always available options were soup, chicken salad sandwich, chicken salad, and hamburger. A review of the Food Committee Meeting Minutes dated 03/18/24 showed there were requests for more chef salads. On 06/12/24 at 12:58 p.m., the Kitchen Manager stated Resident #59 did not like pork, chicken, turkey, beef, fish, or shellfish. She stated corporate changed the menu and they no longer offer chef salads. On 06/12/24 at 11:24 a.m., the Administrator stated she would have to check to see why Resident #59 could not get a chef salad.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39438 Based on observation, record review, and interview, the facility failed to ensure food was labeled and dated, the floor in the walk in freezer was clean, and personal belongings were stored appropriately in one of one kitchen. Findings included: On 06/09/24 at 9:31 a.m., an initial tour of the kitchen was conducted. Two bags of opened pasta were observed with no date. There was a clear container of brown liquid in the walk-in cooler with no date. Pieces of paper and other trash were observed on the floor in the walk-in freezer. The Kitchen Manager confirmed the floor was dirty and stated today was cleaning day. There was an unknown food wrapped in plastic wrap with no label or date in the walk-in freezer. There was a container of cereal observed underneath the prep table in the food prep area with no date. A jacket was observed hanging from a dish rash where clean dishes were stored. On 06/12/24 at 11:59 a.m., the Kitchen Manager stated food should be labeled and dated as soon as items are put in a container or opened. She stated they have hangers for jackets. The Labeling and Dating Inservice undated provided by the facility revealed the following: Importance of Labeling and Dating Proper labeling and dating ensures that all foods are stored, rotated, and utilized in a First In First Out manner. This will minimize waste and ensure that items that are passed their due dates are discarded. Guidelines for Labeling and Dating All foods should be dated upon receipt before being stored. Leftovers must be labeled and dated with the date they are prepared and the use by date.