

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>105587</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/19/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASPIRE AT COUNTRYSIDE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3825 COUNTRYSIDE BLVD N PALM HARBOR, FL 34684</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  A complaint survey for complaint numbers 2024013933, 2025000752 and 2025001432 was conducted on _____ to _____ at Aspire at Countryside. The facility was not in compliance with 42 CFR, Part 483, Requirements for Long Term Care Facilities.  Complaint numbers 2025001432 and 202500752 had no deficiencies. Complaint number 2024013933 had a deficiency cited at F656.	F 000			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and _____ needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and _____ well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

/2025

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.

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F 656	<p>Continued From page 1</p> <p>recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>( ) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and -informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interviews, the facility did not ensure a care plan was updated to include individualized interventions related to behaviors after a reported event were included in the care plan for one (#1) of two residents reviewed.</p> <p>Findings included:</p> <p>On _____ at 12:25 p.m., an interview with Staff A, _____, Assistant (PTA) revealed she had witnessed a reported event that occurred on _____, where Resident #1 was involved. She stated, "[Resident name] was actively performing a _____ act on another resident." Staff A, PTA</p>	F 656	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider for the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>F656 Develop/Implement Comprehensive Care Plan</p> <p>What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>1. Facility updated Care Plan of resident #1 on _____.</p>		

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F 656	<p>Continued From page 2</p> <p>stated Resident #1 was grinning/smiling. She stated she asked Resident #1 what he was doing, but she couldn't recall if he answered. She stated Resident #1 is not known to her as he was not the resident she was working with for ( . . . ), but it was the other resident who was on her caseload.</p> <p>Review of Resident #1's admission record revealed an admission date of _____ with diagnoses to include _____ wasting and atrophy, not elsewhere classified, multiple sites, _____, unspecified, major recurrent, unspecified, unspecified unspecified severity, without behavioral disturbance, _____ disturbance, disturbance, and _____, and _____ communication _____.</p> <p>Review of Resident #1's record revealed he had documented behaviors of self-exposure that had not been added to the care plan prior to the incident that occurred on _____. The review further showed there were no added interventions related to Resident #1 performing _____ acts on other residents or interventions to prevent future incidents. Record review revealed the following:</p> <p>Review of Resident #1's current care plan revealed "[Resident name] has behaviors (playing with penis outside clothes) r/t [related to] _____, personal choice," with a date initiated/revision on _____. Review of goals for this care plan focus revealed the following, "[Resident name] will have fewer episodes of penis showing by review date. Date initiated: _____. Revision on: _____. Target date: _____. Review of interventions for this care plan focus included the following, "</p>	F 656	<p>How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken:</p> <p>1. On _____, in house quality review was completed to ensure residents exhibiting behaviors have accurate and updated care plans with a focus of ensuring a person-centered approach with resident rights set forth at 483.10(c)(2) and 483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and _____ needs that are identified in the comprehensive assessment. Any outstanding issues or concerns were addressed as they were identified.</p> <p>What measures will be put in place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>1. On _____ the Regional Director of Clinical Services in-serviced the Interdisciplinary Team (IDT) on the components of this regulation and the facility policy regarding plans of care with an emphasis on person-centered care.</p> <p>2. Facility staff were reeducated by the Assistant Director of Nursing/designee on Plans of Care policy and procedure with an emphasis on person-centered care.</p> <p>3. Newly hired employees and contract staff will receive education during orientation.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not</p>		



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F 656	<p>Continued From page 4</p> <p>tablet by twice daily for</p> <p>Start date</p> <p>(HCl) Oral Tablet 10 MG</p> <p>( ), Give 1 tablet by one time a day related to unspecified without behavioral disturbance. Start date</p> <p>HCl Oral Capsule 20 MG ( HCl). Give 1 capsule by daily related to major recurrent, unspecified.</p> <p>Start date</p> <p>On at 2:35 p.m., an interview with Staff C, Advanced Practice Registered Nurse (APRN) revealed she was not aware Resident #1 had a history of exposing himself or behaviors prior to . She replied, "Yes and no," when asked if the documented history of exposing himself could have been a precursor to the event that occurred on . Staff C, APRN stated she has follow-up encounters with the resident, "Every four weeks or so." She confirmed she followed Resident #1 for his , diagnoses. Staff C, APRN stated she reviewed resident's behaviors and/or any issues with facility staff. She said nobody had communicated to her about behaviors prior to</p> <p>On at 2:48 p.m., an interview with Staff B, Certified Nursing Assistant (CNA) revealed on the day the event occurred, she was walking down the hall looking in resident's rooms. She stated Staff A, PTA observed the contact between the two residents first. Staff B, CNA stated Resident #1, "Is not supposed to be in females room." She stated, "When he's in another person's room, he's up to no good." Staff B, CNA stated that's the only event she knew about regarding Resident #1. She said Resident #1 was not exposed during the event she observed on . Staff B, CNA</p>	F 656			

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F 656	<p>Continued From page 5</p> <p>stated Resident #1 liked to expose his _____ and, "Play with himself." Staff B, CNA stated she doesn't think he does it towards someone or he intended to show people. She stated, "That's just him."</p> <p>On _____ at 3:58 p.m., an interview was conducted with the Nursing Home Administrator (NHA) regarding the _____ reported incident between Resident #1 and another resident. The NHA stated as a result of the investigation, Resident #1's care plan was updated with a goal, "To reduce number of exposures." He stated Resident #1's care plan in place correlates with the event on _____. The NHA confirmed there were no interventions in place prior to even though the resident had known behaviors.. He confirmed through his interviews with the staff who witnessed the resident's contact, there were observations of Resident #1 exposing himself, and performing a _____ act on another resident. The NHA stated Staff B, CNA's feedback was the resident had a history of exposing himself. He stated there had been no incident of Resident #1 exposing himself since he became the NHA at this facility. The NHA stated he was not aware of a _____ note from _____ about Resident #1 exposing himself to female residents. He stated during the investigation he did not review previous records. The NHA stated the previous Director of Nursing (DON) would have reviewed the _____ note from _____, brought it to the Interdisciplinary team (IDT) meeting, and discussed as a team/collaborated on interventions to update Resident #1's care plan.</p> <p>On _____ at 10:16 a.m., an interview with the NHA revealed Resident #1's Kardex and care plan, "Could be more meaningful." He stated the</p>	F 656			

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F 656	Continued From page 6 current care plan in place is for exposing himself and confirmed there were no interventions in place specific to the event that occurred on when Resident #1 was observed in a act with another resident.  Review of the facility's policy titled Plans of Care, dated and a revision date of revealed the following. " ... Procedure: ... Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident in response to current interventions after the completion of each OBRA (Omnibus Budget Reconciliation Act) MDS (Minimum Data Set) assessment (except discharge assessments), and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and , , well-being."	F 656			

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N 000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint survey for complaint numbers 2024013933, 2025000752, and 2025001432 was conducted on _____ to _____ at Aspire at Countryside. Deficiencies were identified at the time of the survey.</p> <p>Complaint numbers 2025001432 and 202500752 had no deficiencies. Complaint number 2024013933 had a deficiency cited at F656.</p>	N 000		
N 072 SS=D	<p>59A-4.109(2), FAC; Comprehensive Care Plans</p> <p>59A-4.109 FAC</p> <p>(2) The nursing home licensee develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and _____ needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility did not ensure a care plan was updated to include individualized interventions related to behaviors after a reported _____ event were included in the care plan for one (#1) of two residents reviewed.</p> <p>Findings included:</p>	N 072	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider for the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>Develop/Implement Comprehensive Care Plan What corrective action (s) will be</p>	

AHCA Form 3020-0001  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Electronically Signed

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N 072	<p>Continued From page 1</p> <p>Review of the facility's policy titled Plans of Care, dated _____ and a revision date of _____ revealed the following. " ... Procedure: ... Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident in response to current interventions after the completion of each OBRA (Omnibus Budget Reconciliation Act) MDS (Minimum Data Set) assessment (except discharge assessments), and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and _____ well-being."</p> <p>On _____ at 12:25 p.m., an interview with Staff A, _____, Assistant (PTA) revealed she had witnessed a reported event that occurred on _____, where Resident #1 was involved. She stated, "[Resident name] was actively performing a _____ act on another resident." Staff A, PTA stated Resident #1 was grinning/smiling. She stated she asked Resident #1 what he was doing, but she couldn't recall if he answered. She stated Resident #1 is not known to her as he was not the resident she was working with for ( _____ ), but it was the other resident who was on her caseload.</p> <p>Review of Resident #1's admission record revealed an admission date of _____ with diagnoses to include _____ wasting and atrophy, not elsewhere classified, multiple sites, _____, unspecified, major _____, recurrent, unspecified, unspecified severity, without behavioral disturbance, _____ disturbance, _____ disturbance, and _____, and _____ communication _____.</p>	N 072	<p>accomplished for those residents found to have been affected by the deficient practice:</p> <p>1. Facility updated Care Plan of resident #1 on _____.</p> <p>How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken:</p> <p>1. On _____, in house quality review was completed to ensure residents exhibiting behaviors have accurate and updated care plans with a focus of ensuring a person-centered approach with resident rights set forth at 483.10(c)(2) and 483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and _____ needs that are identified in the comprehensive assessment. Any outstanding issues or concerns were addressed as they were identified.</p> <p>What measures will be put in place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>1. On _____ the Regional Director of Clinical Services in-serviced the Interdisciplinary Team (IDT) on the components of this regulation and the facility policy regarding plans of care with an emphasis on person-centered care.</p> <p>2. Facility staff were reeducated by the Assistant Director of Nursing/designee on Plans of Care policy and procedure with an emphasis on person-centered care.</p> <p>3. Newly hired employees and contract staff will receive education during _____.</p>	
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N 072	<p>Continued From page 2</p> <p>Review of Resident #1's record revealed he had documented behaviors of self-exposure that had not been added to the care plan prior to the incident that occurred on . The review further showed there were no added interventions related to Resident #1 performing acts on other residents or interventions to prevent future incidents. Record review revealed the following:</p> <p>Review of Resident #1's current care plan revealed "[Resident name] has behaviors (playing with penis outside clothes) r/ [related to] , personal choice," with a date initiated/revised on . Review of goals for this care plan focus revealed the following, "[Resident name] will have fewer episodes of penis showing by review date. Date initiated: . Revision on: . Target date: . Review of interventions for this care plan focus included the following, " and meet The resident's needs ... Assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately. ... Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her when passing by. ... If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. ... Intervene as necessary to protect the rights and safety of others. Approach/Speak in calm manner. Divert attention. Remove from situation and take to alternate location as needed."</p> <p>Review of Resident #1's , assessments and progress notes revealed the following on date of service . "Reason for Visit: Exposing himself to female residents. ... History</p>	N 072	<p>orientation.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: During Morning meeting, the Director of Nursing (DON) and/or designee will review occurrence of behaviors documented from previous day, and/or post psy( /chiatry) documentation review, to ensure Care Plans are updated accordingly, daily 5 times a week for 4 weeks, then weekly for 4 weeks, then random Care Plans every other week, to ensure Care Plans are person-centered and accurate, until the QAPI committee finds that the facility has met substantial compliance. Date Certain:</p>	

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N 072	<p>Continued From page 3</p> <p>of Present Illness: ... Nursing staff reports , [patient] exposing his to passing female residents, then puts it under his shorts. ... Discussed options with [family member] via phone. She would like to utilize pharmacologic intervention and bring in some long sweat pants to hopefully prevent himself from exposing his ... next f/u [follow up]: prn [as needed]."</p> <p>Review of Resident #1's care conference record quarterly assessment, dated , revealed the following, "...Comments: ... [family member] concerned about recent touching behaviors and will be bringing long sweatpants for when he is up in wheelchair. ..."</p> <p>Review of Resident #1's active physician orders revealed the following:                  Oral Tablet Delayed Release 250 Milligrams [MG] ( ). Give 1 tablet by twice daily for                  Start date                  (HCl) Oral Tablet 10 MG ( ). Give 1 tablet by one time a day related to unspecified without behavioral disturbance. Start date                  HCl Oral Capsule 20 MG ( HCl). Give 1 capsule by daily related to major , recurrent, unspecified.                  Start date</p> <p>On at 2:35 p.m., an interview with Staff C, Advanced Practice Registered Nurse (APRN) revealed she was not aware Resident #1 had a history of exposing himself or behaviors prior to . She replied, "Yes and no," when asked if the documented history of exposing himself could have been a precursor to the event that occurred on . Staff C, APRN stated she has follow-up encounters with the resident,</p>	N 072		
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NAME OF PROVIDER OR SUPPLIER  ASPIRE AT COUNTRYSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 3825 COUNTRYSIDE BLVD N PALM HARBOR, FL 34684
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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N 072	<p>Continued From page 4</p> <p>"Every four weeks or so." She confirmed she followed Resident #1 for his , , diagnoses. Staff C, APRN stated she reviewed resident's behaviors and/or any issues with facility staff. She said nobody had communicated to her about behaviors prior to .</p> <p>On at 2:48 p.m., an interview with Staff B, Certified Nursing Assistant (CNA) revealed on the day the event occurred, she was walking down the hall looking in resident's rooms. She stated Staff A, PTA observed the contact between the two residents first. Staff B, CNA stated Resident #1, "Is not supposed to be in females room." She stated, "When he's in another person's room, he's up to no good." Staff B, CNA stated that's the only event she knew about regarding Resident #1. She said Resident #1 was not exposed during the event she observed on . Staff B, CNA stated Resident #1 liked to expose his , and, "Play with himself." Staff B, CNA stated she doesn't think he does it towards someone or he intended to show people. She stated, "That's just him."</p> <p>On at 3:58 p.m., an interview was conducted with the Nursing Home Administrator (NHA) regarding the reported incident between Resident #1 and another resident. The NHA stated as a result of the investigation, Resident #1's care plan was updated with a goal, "To reduce number of exposures." He stated Resident #1's care plan in place correlates with the event on . The NHA confirmed there were no interventions in place prior to even though the resident had known behaviors.. He confirmed through his interviews with the staff who witnessed the resident's contact, there were observations of Resident #1 exposing himself, and performing a act on another resident.</p>	N 072		
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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>55263</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/19/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ASPIRE AT COUNTRYSIDE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3825 COUNTRYSIDE BLVD N PALM HARBOR, FL 34684</b>
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N 072	<p>Continued From page 5</p> <p>The NHA stated Staff B, CNA's feedback was the resident had a history of exposing himself. He stated there had been no incident of Resident #1 exposing himself since he became the NHA at this facility. The NHA stated he was not aware of a , , note from about Resident #1 exposing himself to female residents. He stated during the investigation he did not review previous records. The NHA stated the previous Director of Nursing (DON) would have reviewed the , , note from , brought it to the Interdisciplinary team (IDT) meeting, and discussed as a team/collaborated on interventions to update Resident #1's care plan.</p> <p>On at 10:16 a.m., an interview with the NHA revealed Resident #1's Kardex and care plan, "Could be more meaningful." He stated the current care plan in place is for exposing himself and confirmed there were no interventions in place specific to the event that occurred on when Resident #1 was observed in a act with another resident.</p> <p>CLASS III</p>	N 072		
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