STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105611	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Greenacres	6414 13th Rd S Green Acres, FL 33415

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record review, the facility failed to provide care in a manner to maintain a resident's dignity for 47 residents on the South unit, including Resident #18. The findings included: The facility's policies and procedures for Dignity did not address dignity during dining. 1). Resident #18 was admitted to the facility on [DATE]. According to the resident's most recent assessment, a Quarterly Minimum Data Set (MDS), dated [DATE], Resident #18 had a Brief Interview fore Mental Status score of 02, indicating severe cognitive impairment. The MDS documented that the resident was dependent upon staff for eating. Resident #18's diagnoses at the time of the assessment included: Anemia, Diabetes, Cerebrovascular incident, Non-Alzheimer's Dementia, Hemiplegia, Seizure disorder, Malnutrition, Depression, Epilepsy, contracture of muscle left upper arm. Cognitive communication deficit, Dysphagia, Muscle weakness, Limitation of activities due to disability. During an observation of breakfast, on 03/12/24 08:43 AM, it was noted that Resident #18 had not been served breakfast. During an interview with Staff A, LPN, while standing directly outside of the resident's room, when asked about Resident #18 not being served breakfast, Staff A replied, She is a feeder, when the CNA (Certified Nurse's Assistant) is finished with another resident, she will feed her. 2). On 03/13/24 at 8:25 AM, Resident #18 was observed in bed with breakfast on over bed table and being fed by Staff B, LPN. It was noted that Staff B was standing at the resident's right side of bed to feed her. When asked about standing next to the resident Staff B acknowledged that she should have been seated to feed the resident, There wasn't a chair in the room, and I recognized that the food was getting cold. 3). During an observation of lunch being served to the residents in their rooms on the South Unit, on 03/13/24 at 11:58 AM, Staff C, CNA was instructed to go to the dining room by another staff member. Staff C replied by yelling out, I can't, I have feeders. At the time of the observation, Staff C was at the room at the end of the unit close to the emergency exit and could be heard by this Surveyor from the nurse's station, approximately 90 feet from away, according to the Regional Director of Plant Operations. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Staff C at the time of the observation, Staff C acknowledged that she had referred to the residents as feeders and understood the concerns. During an interview, on 03/13/24 at approximately 12:30 PM, the Administrator acknowledged understanding of the concerns and replied that the staff would be in-serviced. During an interview, on 03/14/24 at 3:00 PM, the Regional Nurse Consultant stated that the facility did not have a policy and procedure specific to dignity during dining.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on record review and interview, the facility failed to ensure that a complete and accurate Pre-Admission Screening and Resident Review (PASARR) was completed for 1 of 2 residents reviewed, Resident #60. The findings included: Resident #60 was admitted to the facility on [DATE]. According to the resident's most recent assessment, a Quarterly Minimum Data Set (MDS), dated [DATE], Resident #10 had a Brief Interview for Mental Status score of 10, indicating that the resident was moderately cognitively impaired. In Section IA of the resident's PASARR, completed by the resident's Attending Physician on 05/11/23, the PASARR documented that Resident #60 had diagnoses that included: Anxiety Disorder, Depressive Disorder and Agoraphobia. Section 1B of the PASARR documented that Resident #60 had functional limitations in major life activities that included: Capacity for independent living, Self-care, and Self direction. Section I documented that the resident previously received services for Mental illness and had been referred for Mental Illness Services. The findings of the Level I PASARR was based on documented History, Behavioral Observations and Medications. Sectio II-2 of the PASARR documented that the resident had the following difficulties with: Interpersonal functioning, Concentration, persistence and pace, and Adaptation to change. Section II-3 of the PASARR documented, Due to the mental illness, the individual has experienced an episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in interventions by housing or law enforcement. The PASARR instructs the person that is completing the assessment, A Level II PASARR evaluation must be completed prior to admission if any box in Section 1.A or 1.B is checked and there is a 'yes' checked in Section II.1, II.2 or 11.3, unless the individual meets the definition of a provisional admission or a hospital discharge exemption. Section IV of the PASARR was not completed to determine if Resident #60, 'may be admitted to an NF. During an interview, on 03/14/24 at 3:33 PM with the Social Services Director, when asked about Resident #60's PASARR not being completed, the Social Services Director stated, I submitted for a Level II and it was declined. The Social Services Director provided documentation of a response from the request for the Level II screening, dated 02/27/24, that documented: We can't complete the screening. This case is being closed due to an incomplete submission packet. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Services Director stated that she had not followed up on the response to the request being declined.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observation, interview and record review, the facility failed to provide activities to meet the needs and interests for 1 of 2 residents reviewed for Activities, Resident #60. The findings included: Resident #60 was admitted to the facility on [DATE]. According to the resident's most recent assessment, a Quarterly Minimum Data Set (MDS), date 12/27/23, Resident #60 had a Brief Interview for Mental Status score of 10, indicating that the resident was moderately cognitively impaired. The MDS documented that Resident #60 required substantial/maximal assistance for activities of daily living, except for eating. Resident #60's diagnoses at the time of the assessment included: Anxiety disorder, Depression, Psychotic disorder, Rheumatoid arthritis, Agoraphobia, Chronic pain. A care plan, dated 12/27/23, with a revision date of 03/11/24, documented, The resident experiences loneliness and or isolation. The goal of the care plan was documented as, The resident will express feelings around loneliness and isolation with a target date of 05/30/24. Interventions to the care plan included: Encourage resident to express feelings of loneliness and isolation. Further review of Resident #60's electronic health record revealed that there was no care plan for Activities. A 'Community Life Progress Review (Activities assessment), dated 01/03/24, documented that the resident 'Prefers to watch TV'. On 03/12/24 at 9:58 AM, Resident #60 was observed in bed in wearing a hospital gown. The resident's roommate stated that Resident #60 had not been out of bed during the previous 3 weeks. When Resident #60 was asked if the statement by her roommate was accurate, Resident #60 nodded agreement with the statement made by the roommate. The resident was informed by this Surveyor about the activity involving Baking Cookies that was scheduled for this day in the afternoon and resident was visually excited to attend. During the interview and observation, it was noted that the television was turned off and the remote control for the television was on the resident's overbed table that was not in the resident's reach. On 03/12/24 at 2:29 PM 8 residents were observed in the Activity room while cookies were being baked for the residents and the residents were being served beverages by the Activities staff. It was noted that Resident #60 was not among the 8 residents in attendance. Interview with resident - was asked if she wanted to attend the activity and nodded head up and down in a 'yes' manner. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 03/12/24 at 2:34 PM Staff F CNA, when asked about Resident #60 being out of bed and participating in activities, Staff F replied, she just moved rooms. It is not normal for her to be in bed. Sometimes she gets up. I washed and put a clean gown on her. There was no clean clothes in the closet. On 03/12/24 at 2:40 PM, an observation of Resident #60's closet noted that there were 3 pairs of pants and several shirts. Resident #60 confirmed that the clothing was hers and was unsure of any missing clothing since being moved from another unit. During an interview, on 03/13/24 at 7:14 AM, with Staff G, LPN, when asked about Resident #60's participation in activities and being out of bed, Staff G replied, She has therapy get her out of bed, sometimes she wants to stay in bed and you cannot force them to get out of bed. The CNAs get them in the chair and the Activities come and get them. When asked of the most recent time that Resident #60 had been out of bed, Staff G replied, a couple of weeks ago before lunch. I think it was for activities. During an interview, on 03/13/24 at 7:27 AM, with Staff A, LPN, when asked about Resident #60 being out of bed and participating in activities, Staff A replied, yesterday was the first day that I worked with her for a while. Her roommate said that she didn't feel like getting up. After PT, she will go to activities. The Activities will come and ask them if they want to go. During an interview, on 03/13/24 at 10:15 AM, the Activities Director stated that she tries getting residents to do exercise, they don't want to, they just want to sit and drink coffee. Every once in a while a couple of them will, but this is what they want. On 03/13/24 at 4:55 PM, Resident #60 was observed in her wheelchair in her room, with the television turned off and the remote control for the television on the overbed table that was out of the resident's reach and no other source of stimulation noted. During an interview, on 03/13/24 at 5:39 PM, with The Therapy Director, when asked about Resident #60 participating in therapy, the Therapy Director replied, I just finished with her - 03/11/24 was my last day with her. Speech Therapy projected discharge is tomorrow (03/14/24). I usually work with her in the room. When asked about assisting the resident to Activities at the completion of therapy, the Therapy Director replied, more often than not she would rather sit in her room and watch TV. When asked about the resident's physical and cognitive ability to operate the television remote control, the Therapy Director replied, her cognition is not as good. She has her good days and her not so good days. If she had a good night, she is more engaging and alert. Her cognition varies. She has the physical capacity to use the remote, but not always the cognitive ability. On 03/14/24 at 10:15 AM, Resident #60 was observed in bed with television off and remote control on over bed table that was out of the resident's reach and no other source of stimulation noted. During an interview, on 03/14/24 at approximately 10:30 AM, with the Activities Director, the Activities Director stated that she had started a care plan for Activities for the resident this morning. The Activities Director further stated that the resident also enjoys books and 1:1 visits. During the observation and interview, Resident #60 was in bed with television off and remote control out of reach and books on her nightstand to the resident's right side of bed also out of reach.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interviews, policy and record review; the facility failed to provide care and services to prevent a potential decline in a resident's physical and/or psychosocial well-being for 1 of 5 sampled residents, reviewed for unnecessary medications (Resident #62). The findings included: The facility's policy titled, Medical Care/Standard of Practice with an effective date of 11/30/14 and revision date of 03/03/21, revealed The attending physician will complete a history and physical (H&P) on all residents as required by the applicable state law. In the event the admitting physician is new to the resident, the admitting physician shall complete an H&P on the resident within 48 hours of admission. Resident #62 was admitted to the facility on [DATE] post hospitalization for Personal history of traumatic brain injury, Pedestrian on foot injured in a motor vehicle accident and Traumatic subarachnoid hemorrhage with loss of consciousness. Resident #62 was unable to perform the Brief Interview for Mental Status (BIMS) and was unable to speak. In an interview with the resident on 03/11/24 at 10:15 AM the resident was able to nod her head to indicate that she understood the questions asked but could not respond except for nodding her head. Upon admission to the facility, the resident was on Enoxaparin Sodium (Lovenox) Injection Solution Prefilled Syringe 30 milligrams (mg) per 0.3 milliliter (ml). Instructions were to inject 30 mg intramuscularly two times a day for DVT (deep vein thrombosis). Enoxaparin sodium is an anticoagulant that helps to prevent formation of blood clots. A review of Enoxaparin sodium was done on the Food and Drug Administration (FDA) site. Lovenox (Enoxaparin sodium) must not be administered by intramuscular injection. Lovenox (enoxaparin sodium injection), is for subcutaneous and intravenous use. Thrombocytopenia can occur with the administration of Lovenox. Periodic complete blood counts, including platelet count, and stool occult blood tests are recommended during the course of treatment with Lovenox. A review of the medical chart revealed the H&P was done on 01/08/24. A review of the nursing progress notes and Medication Administration notes revealed on 03/08/24 at 9:35 AM the resident refused Enoxaparin Sodium. The note read she was crying MD (Medical Doctor) notified. On 03/08/24 a nursing progress note read Patient refused am Lovenox injection, crying saying No, no it hurts too much Dr notified, who said, noted. On 03/09/24 a medication administration note stated refused, MD notified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/10/24 a medication administration note read I don't want it, it hurts. Dr . made aware. Attempted to call the nurse who wrote these notes on 03/13/24 at 3:53 PM but she did not answer the phone. An interview was conducted with Staff D, Regional Director of Clinical Services, on 03/14/24 at 4:45 PM who stated that the nurse had to be referring to the Enoxaparin since it was not given those three days and all other medications were given. Staff D also stated at this time that she had been trying to reach the Physician to have the Enoxaparin Sodium discontinued and after 4 attempts to reach him, he still did not answer her. An interview was conducted with Staff E, the Consultant Pharmacist, on 03/13/24 at 09:42 AM. She produced a pharmacy review dated 01/31/24 for a recommendation for a stop date for Enoxaparin. The recommendation for a person with an acute illness with decreased mobility was a FDA approved duration of up to 14 days 30 mg twice a day and up to 3 months with 40 mg daily. Resident #62 had been taking 30 mg twice a day since 12/28/23. The resident's last Complete Blood Count (CBC) was done 01/03/24 with an order for it to be repeated in 90 days. An interview was done with Resident #62's Physician on 03/14/24 at 12:06 PM. The Physician was asked why the H&P was late on Resident #62 and he had no response as to why. The Physician was asked how long should Resident #62 have been on Enoxaparin Sodium and he replied she should have been taking it for 2 weeks. When asked why he did not respond to the recommendation of the consultant pharmacist to provide a stop date on 01/31/24 he replied that he did not see the recommendation. He stated that he wanted Resident #62 to see a trauma doctor to regulate the Enoxaparin Sodium for which he told the Director of Nurses. When asked where the referral was for her to see a trauma doctor he stated he probably did not write one and he will do better next time. When asked where the progress notes were from his visits to Resident #62 in January 2024 and February 2024 he stated they were in his office and he will email them. On 03/14/24 at 4:00 PM the progress notes arrived to the facility. Reviewed the notes for January and February 2024. On 02/24/24 the Physician wrote under medications that the resident was receiving Lovenox indicating he was aware that she was still taking this medication. The Lovenox was discontinued on 03/13/24.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to provide services to prevent further decrease in range of motion for 1 of 1 resident reviewed for range of motion, Resident #18. The findings included: Resident #18 was admitted to the facility on [DATE]. According the resident's most recent assessment, a Quarterly Minimum Data Set (MDS), dated [DATE], Resident #18 had a Brief Interview for Mental Status score of 02, indicating the resident was severely cognitively impaired. The MDS documented that Resident #18 was dependent upon staff for all Activities of Daily Living. Resident #18's diagnoses at the time of the assessment included: Diabetes, Cerebrovascular Accident, Non-Alzheimer's Dementia, Hemiplegia, Seizure disorder, Malnutrition, Depression, Epilepsy, contracture of muscle left upper arm. Cognitive communication deficit, Dysphagia, Muscle weakness. Resident #18's orders included: Splint. Resting hand splint left hand for up to 8 hours as tolerated, on in the AM/PM off. Monitor skin integrity before application and removal of device - 02/26/24. Resident #18's care plan for Activities of Daily Living (ADLs), initiated on 11/21/18 with a revision date of 10/17/22, documented, Resident has an ADL self-care performance deficit related to a history of cerebrovascular accident, hemiplegia, impaired mobility, arthritis to bilateral knees Non-compliant with left hand splint. The goal of the care plan was documented as, The resident will maintain current level of function in ADLs and mobility thru next review date with at target date of 05/05/24. Interventions to the care plan included: *Encourage and assist with turning and repositioning every shift and PRN. *Left resting hand splint to be worn 8 hours or as tolerated daytime wear, maintain clean dry hand with nails cut to prevent skin breakdown. On 03/12/24 at 9:06 AM, Resident #18 was observed in bed with the head of bed elevated. It was noted that Resident #18 was not wearing a splint device on either hand. On 03/12/24 at 11:49 AM Resident #18 was observed in her wheelchair at the nurse's station and did not have a splint or device on her hand. On 03/12/24 at 1:48 PM, Resident #18 was observed in in her wheelchair at the nurse's station and did not have a splint or device on her hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24 10:18 AM, Resident #18 was observed up in high backed wheelchair in her room and did not have a splint device on her hand. On 03/13/24 at 11:25 AM, Resident observed in high back wheelchair in Activities room and did not have a splint device on her hand. A review of Resident #18's electronic health record revealed no documentation of the resident refusing or not tolerating the use of the splint device. On an ADL task worksheet, CNA (Certified Nursing Assistants) staff documented that the resident wore the splint device daily for the previous 2 week period, including during the observations made and documented by this Surveyor. On another worksheet, CNA staff documented that the device was put on daily and that the device was only documented to be removed once. During an interview, on 03/13/24 at 11:56 AM, with Staff F, CNA, when asked about applying the splint device to Resident #18's left wrist and hand, Staff F replied, I put it on when I got her up in the morning at around 10:00 when they put her to bed, they take it off. I leave at 3:30 she had the brace on when I left. Sometimes it hurts and she doesn't have it on for very long. At the conclusion of the interview, Staff F was asked to show this Surveyor the device. Saff F led this Surveyor to the resident's room. Upon arriving to the resident's room, Staff F was unable to locate the device immediately. After a few minutes, the splint device was found in the top drawer of the night stand to the resident's right side of bed. Staff F confirmed that she was the staff member that documented putting the splint device on the resident on the task worksheet. During an interview, on 03/13/24 at 4:38 PM with Staff H, CNA for 8 months, when asked about the use of a splint device for Resident #18, Staff H replied, When I came in, she had the brace and I put her back to bed, when I put her back to bed, I took it off because she can't be in the bed with the brace. Staff further stated that the resident had no problems or pain with the splint device, When I am here, I work 2 days with her and Staff F puts it on and I take it off. Staff confirmed that she was the staff member that documented taking the splint device off of the resident on the ADL worksheet.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 38893 Based on observations, interviews and record reviews, the facility failed to provide services to a resident with Post-Traumatic Stress Disorder (PTSD) in a manner to prevent being further traumatized for 1 of 1 resident reviewed for behavioral health, Resident #51. The findings included: The facility's policy for 'Trauma Informed Care' dated 10/24/22, documented: Residents will be evaluated to identify a history of trauma, triggers and cultural preferences. Resident-centered interventions are initiated based on the resident triggers and preferences to decrease the risk of re-traumatization. Procedure: 1. Residents are evaluated for trauma, triggers, and cultural preferences on admission/readmission, quarterly and annually. 2. Develop resident-centered interventions based on trauma triggers and resident cultural preferences. 3. Develop a care plan and add interventions to the nurse aide Kardex. 4. Review and update care plan and intervention quarterly and as needed. Resident #51 was admitted to the facility on [DATE]. According to the resident's most recent assessment, a Quarterly Minimum Data Set (MDS), dated [DATE], Resident #51 had a Brief Interview for Mental Status score of 15, indicating that the resident was cognitively intact. Resident #51's diagnoses upon admission included: Major depressive disorder, Anxiety disorder, Post-Traumatic Stress Disorder, Bipolar disorder, Personal history of suicidal behavior, Nicotine dependence and Tachycardia. Resident #51's care plan for Activities of Daily Living (ADLs), initiated on 03/16/23 with a revision date of 03/25/23, documented, The resident has an ADL self-care deficit related to Rheumatoid Arthritis, Obesity, PTSD, Depression, Anxiety, and Neuropathy. Further review of Resident #51's records revealed no care plan related to the resident's diagnosis of PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #51, on 03/11/24 at 2:56 PM, when asked about the diagnosis of PTSD, Resident #51 stated, I have PTSD from being raped when I was 8 years old until I was 12. When asked about the triggers associated with the diagnosis of PTSD, Resident #51 replied, Yelling and loud screaming and I can't look at knives. My daughter was murdered in front of me. They have me on Prezacin for night terrors and I think that it needs to be changed - over the past couple of nights, I have been having very vivid dreams about my brother and my daughter. I guess we are waiting on the psychiatrist - she wasn't here yesterday. I don't get angry at other people. I was told that I have survivor's guilt. During an interview, on 03/13/24 at 7:09 AM, with Staff G, LPN, when asked about Resident #51's PTSD and behaviors, Staff G replied, sometimes when she speaks with other residents, she gets agitated and sometimes she is crying because of her children. She tells a story that she was raped. I don't really know what happens that she gets agitated when talking to the other residents. When asked about the triggers and behaviors associated with them, Staff G replied that she was not aware of triggers. During an interview, on 03/13/24 at 7:24 AM, with Staff A, LPN, when asked about Resident #51's behavior, Staff A replied, She is like sometimes confused, she can tell you something and then she will forget. She has a mood where sometimes she talks a lot, and she cries. For me she always laughs, I talk with her, and she likes that. When asked about Resident #51's PTSD and the triggers and behaviors associated with the PTSD, Staff A replied, I'm not really sure. For me she is always good and happy, she never gets angry and mad with me. She likes when I am working with her. She gets ibuprofen and she gets anxiety medications. I can see her mood change after she gets her medications, and she is more relaxed and talking. During an interview, on 03/13/24 at 11:56 AM, with Staff F, CNA, when asked about Resident #51's PTSD and the triggers and behaviors associated the PTSF, Staff F was not able to demonstrate awareness or knowledge of PTSD. During an interview, on 3/13/24 at 4:44 PM, with Staff H, CNA, when asked about Resident #51 having PTSD and the triggers and behaviors associated with the resident's PTSD, Staff H stated that she was not familiar with resident's diagnosis of PTSD or triggers and behaviors. During a follow up interview with Resident #51, on 03/13/24 at 4:52 PM when asked about how she reacts to the triggers to the PTSD, Resident #51 replied, loud noises like yelling and arguing, I will revert back to being like a little girl and pulling my covers up over my head and I become very disconnected. I won't get out of bed and I won't let them provide care. Resident #51 stated that it had most recently happened 'a couple of weeks ago'. During an interview, on 03/14/24 at 3:33 PM, with the Director of Social Services, when asked about there not being a care plan for Resident #51's PTSD and associated triggers and behaviors, and the lack of knowledge of the diagnosis demonstrated by facility staff, the Director of Social Services acknowledged that there was not a care plan. The Social Services Director stated that she would implement a care plan and provide in-service training to the staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105611	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Greenacres	6414 13th Rd S Green Acres, FL 33415

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on record review and interview, the facility failed to respond to pharmacy recommendations for 2 of 5 residents reviewed for unnecessary medications (Residents #28 and #62). The findings included: 1. Resident #28 was admitted to the facility on [DATE] with diagnoses included Diabetes. A comprehensive assessment dated [DATE] documented the resident had mild cognitive impairment, required substantial/maximal assistance with activities of daily living. The assessment further documented the resident was receiving insulin injections, antidepressants, anticoagulants (blood thinners), and diuretics. A 6 month review of Consultant Pharmacist Medication Regimen Review was conducted. The review revealed no physician's response to pharmacy recommendations on 11/30/23, 01/31/24, and 02/19/24. Pharmacy recommendation 02/19/24 : Allegra 180 milligrams at night which was started on 06/18/23. Please consider discontinuing to reduce polypharmacy. Pharmacy recommendation 01/31/24: The resident is taking Montelukast. Montelukast side effects include the following neural psychiatric symptoms and roughly 14% of patients which include agitation, aggression, anger, anxiety, depression, hallucinations, hostility, irritability, nervousness, sleep disorders, and restlessness. May want to consider other drug therapy as Montelukast may be result in the need for anti psychotic drug therapy. Pharmacy recommendation 11/30/23: Insulin solution sliding scale. In an effort to keep this facility compliant to CMS regulations for long term care facilities please evaluate risk for versus benefit of continued use of sliding scale insulin. It is listed on the Beer list of potentially inappropriate drugs in the elderly due to poor efficacy and potential for hypoglycemia. American Diabetes Association advises against utilizing sliding scale as insulin monotherapy in elderly populations. Long term use is generally not recommended. For continued use, rationale and risk versus benefit should be documented in the residents medical record. Recommendation: Please evaluate continued use of sliding scale in light of the above. If blood sugar remains uncontrolled, suggest adjusting routine therapy, if clinically appropriate. If benefits of sliding scale outweigh risk, please document clinical rationale below or in your progress note. Further review of the pharmacy recommendations revealed there is no evidence of any pharmacy review for the months of October 2023 or August 2023. A review of resident #28's current physician orders on 03/14/24 revealed the resident was receiving Allegra, Montelukast, and sliding scale insulin. A review of the resident's physician progress notes did not address the pharmacist recommendations. An interview was conducted with the Consultant Pharmacist on 03/14/24 at 10:00 AM, who acknowledged the above. (continued on next page)

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	105611	A. Building B. Wing	03/14/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	39026 2) Resident #62 was admitted to the facility on [DATE] post hospitalization for Personal history of traumatic brain injury, Pedestrian on foot injured in a motor vehicle accident and Traumatic subarachnoid hemorrhage with loss of consciousness. A review of the Consultant pharmacist recommendations revealed: 12/30/23 no recommendation. 1/31/24 recommendation for stop date for Enoxaparin. 2/19/24 no irregularities. An interview was conducted on 03/13/24 at 9:42 AM with Staff E , the consultant pharmacist, regarding the recommendation to stop Enoxaparin on 01/31/24. She stated she was planning on making another recommendation to discontinue Enoxaparin in March since the recommendation done in January was not acted on. She stated she usually waits a month before repeating a recommendation. Staff E was asked what type of monitoring would be done for a resident on Enoxaparin and she replied that likely a Complete Blood Count (CBC) would be done. An interview was conducted on 03/13/24 at 3:00 PM with Staff D, Regional Director of Clinical Services, who stated there has been no response to the consultant pharmacist's recommendations for Resident #62.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 36734 Based on record review and interview, the facility failed to keep complete and accurate records for 19 of 19 records reviewed (Residents #5, #13, #17, #18, #24, #27, #28, #32, #34, #40, #41, #50, #51, #60, #61, #62, #64, #68, and #222). The findings included: A review of #28's records revealed no physician notes since May 2023. An interview was conducted with the Nursing Home Administrator (NHA) on 03/13/24 at 10:00 AM. The NHA stated the physician progress notes should be in the resident's electronic records and done monthly. Surveyor requested the last 3 months of physician progress notes. The NHA stated she would get in touch with the physician to inquire about the physician notes. An interview was conducted with the NHA on 03/13/24 at 3:00 PM. The NHA produced 3 months of physician notes for 12/24, 01/24, and 02/24. The NHA could not answer why the physician notes were not part of the resident's records. The physician notes were handwritten and illegible. Surveyor requested the last 3 months of physician progress notes for the rest of the sampled residents (Residents #5, #13, #17, #18, #24, #27, #32, #34, #40, #41, #50, #51, #60, #61, #62, #64, #68, and #222). On 03/14/24, the NHA provided written physician progress notes for Residents #5, #13, #17, #18, #24, #27, #32, #34, #40, #41, #50, #51, #60, #61, #62, #64, #68, and #222. The written physician progress notes were illegible. An interview was conducted with the Medical Director/attending physician for the facility's residents on 03/14/24 at 10:00 AM. The Medical Director stated resident's physician progress notes were kept in his office. The Medical Director acknowledged the progress notes should be in the resident's records. The Medical Director stated, I'll do better. When questioned on the illegible written progress notes, the Medical Director stated he did not have access to the electronic medical records for documentation. 39026