STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105951	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Oakfield	1465 Oakfield Dr Brandon, FL 33511

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 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** 49227 Based on interviews and record review, the facility failed to provide necessary treatment to promote healing and prevent infection for an identified pressure ulcer for one (#5) of three residents reviewed. Findings included: Review of Resident # 5's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (3008), dated 10/21/24, showed on 10/6/24, a surgical procedure was performed on the left hip. Review of Resident #5's admission record showed admission to the facility on [DATE] and transferred to the hospital on 11/23/24, with diagnoses to include left femur fracture, muscle weakness, muscle wasting, dementia and on 11/19/24 the onset of stage 3 pressure ulcer of the sacrum on 11/19/24. Review of Resident #5's Order Summary Report showed orders to include consult wound care as needed (PRN), order dated 11/19/24 low air loss mattress for Stage 3 pressure area to coccyx. An order date 11/19/24, start date, 11/20/24 to cleanse sacrum area with wound cleanser and pat dry, apply nickel thick layer of Santyl to wound bed, cover with calcium (CA) alginate and secure with bordered gauze change daily and as needed (PRN) for soiling and dislodgement every day shift for wound care. Review of Resident #5's Admission/ Readmission Data Collection record, dated 10/22/24, Section M: Skin showed right hip surgical incision. Review of Resident #5's Admission Minimum Data Set (MDS), dated [DATE], revealed in Section C: Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 7, which indicated severe cognitive impairment. In Section GG: Functional Abilities revealed Resident #5 required substantial/maximal assistance to roll from lying on back to the left and right sides. In Section M: Skin Conditions revealed Resident #5 is at risk for developing pressures ulcers and does not have one or more unhealed pressure ulcers. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's Treatment Administration Record, dated November 2024 showed an order to cleanse sacrum area with wound cleanser and pat dry, apply nickel thick layer of Santyl to wound bed, cover with calcium (CA) alginate and secure with bordered gauze change daily and as needed (PRN) for soiling and dislodgement every day shift for wound care, start date 11/22/24. Treatment was documented as completed on 11/23/24 only. An order for weekly skin sweeps every night shift every Tuesday for Resident #5 showed skin was checked on 11/5, 11/12 and 11/19. The checks did not reveal concerns with new or worsening of skin conditions. Review of Resident # 5's Nursing Progress Note, dated 10/23/24 at 2:22 A.M. showed .redness to sacrum . Review of Resident #5's Weekly Skin Integrity Review, effective date 10/30/24, showed surgical wound to hip side of thigh and side of left outer knee. Review of Resident #5's Skilled Note, dated 11/4/24, showed skin is moist warm abnormal turgor pale. Review of Resident #5's Weekly Skin Integrity Review, effective date 11/06/24, at 6:31 A.M. showed sacrum wound and mid-back skin breakdown. Review of Resident # 5's Situation, Background, Appearance and Review and Notify (SBAR) form, dated 11/6/24, showed Summoned to room by assigned CNA, resident has two open areas to sacrum and mid back respectively, dry dressing applied, resident repositioned to the left side. The section titled Review and Notify showed the primary care clinician was notified on 11/6/24 at 7:08 A.M. Review of Resident #5's Weekly Skin Integrity Review, effective date 11/06/24, at 2:27 P.M. showed sacrum open area and treatment (Tx) in place. Review of Resident #5's Weekly Skin Integrity Review, effective date 11/13/24, showed sacrum, wound on admission. Review of Resident #5's Weekly Skin Integrity Review, effective date 11/17/24, showed bedsore in her sacrum. Review of Resident #5's Wound Assessment Report, dated 11/19/24, authored by the facility's wound care physician, showed a wound on the sacrum with the following measurements length 6.0 cm (centimeters), width 3.5 cm and depth 0.1 cm. The etiology was a pressure injury, a new stage 3 wound. Additional wound assessment showed 40% granulation, 30% slough and 30% eschar. There was a moderate amount of serous [clear to yellow fluid] exudate [drainage]. The treatment ordered was dressing change daily, clean wound with normal saline, primary treatment Santyl and bordered gauze dressing. Review of Resident #5's Weekly Skin Integrity Review, effective date 11/20/24, showed sacrum wound (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 Resident #5's care plan focused on impaired skin integrity related to immobility and incontinence. The care plan goal was pressure injury will show signs of healing without complications by review date. The care plan interventions include administer treatments as ordered and monitor for effectiveness, assess/ record/monitor wound healing at least weekly, monitor nutritional status. Served diet as ordered. Monitor intake and record. Notify medical doctor (MD) if any deterioration in wound status. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated, initiated on 11/19/24. On 1/13/25 at 2:50 P.M. during an interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA), the DON said at the time of Resident #5's admission to the facility, Zinc Oxide ointment was applied to the buttocks. She verified there was not an order for this medication. The DON said on 11/6/24 when the wounds were identified, there should have been pressure wound care orders and verified no orders were documented. She said on 11/19/24 when the pressure ulcer was documented by the wound care physician, she expected wound care orders, and documentation the treatment was completed as ordered. After reviewing Resident #5's TAR (Treatment Adminsitration Record) the DON confirmed between 11/19/24 and 11/23/24 wound care was documented only on 11/23/24. Review of a facility policy titled, Pressure Injury Record, revision date 4/1/17 showed a 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. The procedure showed: 1. Residents will have a pressure injury record completed for each skin impairment that is related to pressure. Review of a facility policy titled, Skin Evaluation, revised on 4/1/17 showed under policy, A licensed nurse will complete a total body evaluation on each resident weekly . paying particular attention to any skin tears, bruises, stasis ulcers, rashes, pressure injury, lesions, abrasions, reddened areas and skin problems. Under procedure - 1. A licensed nurse will complete a total body evaluation on each resident weekly and document the observation on the skin evaluation form. 2. The evaluated nurse must date & each review. 3. If a resident is assessed as having a skin problem, the evaluating nurse will initiate the appropriate form. For pressure areas complete the Pressure Injury Record. 5. The licensed nurse will document the observations on the skin evaluation form. Review of a facility's policy subject, Physician Orders, revision date 3/3/21 showed: policy - The center will ensure that physician orders are appropriately and timely documented in the medical record. Procedure-routine orders a nurse may accept a telephone order from the physician, physician assistant or nurse practitioner (as permitted by state law). The order will be repeated back to the physician, PA or ARNP for his /her verbal confirmation. The order is transcribed to all appropriate areas of the electronic health record (eMAR (Electronic Medication Administration Record)/eTAR (Electronic Treatment Administration Record). Review of a facility policy titled, Clinical Guideline Skin and Wound, effective date 4/1/17 revealed: Overview 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Process- on admission/ readmission the resident's skin will be evaluated for baseline skin condition and documented in the medical record. Braden Risk Evaluation to be completed on admission /readmission, weekly for four weeks from admission, quarterly and with significant change in condition. Licensed nurse to complete skin evaluation weekly and prior to transfer/ discharge and document in the medical record. CNA (certified Nursing Assistant) to complete skin observations and report changes to licensed nurse. Licensed nurse to document presence of skin impairment/ new skin impairment when observed and weekly until resolved. Licensed nurse to report changes in skin integrity to the physician/practitioner and the resident/ responsible party and document in the medical record . Evaluate the effectiveness of interventions, and progress towards goals during the care management meeting and as needed.