STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106000	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire on Evans	3735 Evans Ave Fort Myers, FL 33901

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25618 Based on record review, and staff interviews the facility failed to ensure consistent documentation of meal intake for 2 (Residents #3 and #9) of 3 sampled residents with significant weight loss to determine the effectiveness of nutritional interventions. The findings included: Review of Resident #3's medical record revealed an admitted [DATE] from an acute care hospital where she was admitted for altered mental status, dehydration and abnormal laboratory results. Review of the Registered Dietitian's (RD) Admission Nutritional Review dated 10/30/24 revealed documentation Resident #3's current weight was 207 pounds (lbs.). The resident's ideal body weight was 135 pounds. The RD noted there were no issues with chewing or swallowing and Resident #3 verbalized no difficulties with chewing or swallowing. The goals were for the stabilization of weight and for meal intake to be greater than 50% for all three meals. On 11/6/24 the RD wrote in a progress note the Unit Manager informed her Resident #3's family was requesting a nutritional supplement related to Resident #3's poor appetite. The resident's current diet was a regular diet, pureed texture, and nectar-thickened liquids. Resident #3's food intake varied from 0% to 100%. The RD added eight ounces of nectar-thickened milk at each meal (8 oz provided 170 kilocalories and 8 grams of protein). The current plan of care would be continued. On 11/08/24 the RD wrote Resident #3's daughter requested to speak with the RD. She reported her mother did not like the pureed diet. Resident #3's daughter was requesting a possible appetite stimulant, and nursing was notified. Review of Resident #3's weight flow sheet revealed the following weights were documented: 10/20/24: 207.0 pounds (lbs.) 11/01/24: 206.4 lbs. 11/11/24: 180.0 lbs. (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/27/24: 177.8 lbs. On 11/17/24 the RD wrote in a weight loss nutritional review Resident #3 triggered a significant weight loss of 13.0% or 27 pounds in 2 weeks that was an unplanned and undesirable. The weight loss was documented to be a likely variable meal intake, and wounds. Nutritional interventions were put into place on 11/06/24. The RD noted on 11/08/24, the family had requested a possible appetite stimulant and nursing was notified. The IDT (interdisciplinary team) and the MD (Medical Doctor) were made aware of the weight loss, current nutritional interventions and new recommendations made. The RD documented they would continue to monitor nutritional status, including meal intake, weight status, diet compliance, labs when available and skin integrity as needed. On 1/08/25 at 2:49 p.m., in an interview the RD she said she came to the facility three days a week. She did nutritional evaluation/assessment for newly admitted residents, residents' monthly and quarterly weight reviews, and any resident who triggered for a significant weight loss or weight gain. She said she used multiple tools to evaluate a resident's nutritional status to include resident and family interviews, resident intake during mealtime observations, staff interviews and staff documentation related to meal intake percentage to assist her with dietary recommendations for each resident. The RD said after reviewing Resident #3's medical record and her progress notes, she confirmed Resident #3 was admitted on [DATE] weighing 207.0 pounds. She said she wrote a progress note on 11/06/24 stating the Unit Manager reported the family was requesting to speak with the RD. She said she spoke with Resident #3's daughter who told her she would like her mother to receive a nutritional supplement due to her poor appetite. She said Resident #3's current meal intake was 0% to 100% so she added 8 oz nectar-thickened milk to each meal. She said on 11/8/24 she spoke to Resident #3's daughter who told her Resident #3 did not like her pureed diet. She was requesting her mother's diet be changed to mechanical soft and asked if her mother could have an appetite stimulant. She told Resident #3's daughter, she would inform the speech therapist of her request to upgrade her mother's diet to mechanical soft. She would inform nursing Resident #3's daughter's request for an appetite stimulant due to her mother not eating. The RD said she informed nursing, and the therapy department of Resident #3's daughter's request to upgrade her mother's diet to a mechanical soft diet and to add an appetite stimulant due to poor intake. The RD said on 11/17/24 she reviewed Resident #3's weights and noted Resident #3's weight was documented on 11/11/24 as 180.0 pounds, which was a 27.0 pound weight loss since her admission, and was a significant weight loss of 13% which was an unplanned and undesirable weight loss. The RD said she had notified the therapy department and nursing on 11/8/24 of Resident #3's daughter's request for a change in diet and an appetite stimulant as she had documented in her 11/8/24 progress note. On 1/9/25 a review of Resident #3's medical record revealed from 11/1/24 through 11/17/24 the nursing staff had not document Resident #3 meal percentage intakes 37 times out of 51 meals as required. Further review of Resident #3's meal intake percentages from 11/23/24 through 12/11/24 revealed the nursing staff did not document 44 meal percentage intakes out of 57 meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/25 at 3:03 p.m., in an interview with the Director of Nursing (DON) after she reviewed Resident #3's medical record, she confirmed Resident #3 was admitted to the facility on [DATE]. She confirmed the RD came to the nursing facility three days a week and did the nutritional evaluation/assessment for newly admitted residents, the residents' monthly and quarterly weight reviews, and any residents who triggered for a significant weight loss or weight gain. She said for continuity the RD reviewed all residents' weekly weights to ensure all significant weight loss and gains were caught and addressed timely. She said the RD as part of her resident nutritional assessment reviewed the resident's medical record and talked with the staff, resident and family and was required to bring her concerns to the IDT meetings. The DON confirmed the nursing staff did not document Resident #3's meal intake percentages 37 times from 11/1/24 through 11/17/24 and 44 times from 11/23/24 through 12/11/24 as required. She said the RD did not inform the IDT in their morning meetings that the nursing staff were not documenting Resident #3's required meal intake percentage as required. She also said the RD did not inform the IDT Resident #3's daughter had requested on 11/8/24 for her mother diet to be upgraded to a mechanical soft diet and the daughter's request for an appetite stimulant for her mother due to her mother's poor food intake as required. 21322 2. Review of the clinical record for Resident #9 revealed an admitted [DATE]. Diagnoses included alcohol dependence, alcoholic cirrhosis of the liver. Review of the resident's weight record revealed on 9/12/24 the resident's weight was 179.89 pounds (lbs.) On 9/25/24 the resident's weight was 188.8. lbs. On 10/2/24 the resident's weight was 177.0 lbs. On 12/5/24 the resident's weight was 174.0 lbs. On 12/12/24 the resident's weight was 154.6 lbs. On 12/13/24 the resident's weight was 155.8 lbs. Review of the progress notes revealed on 11/4/24 the Registered Dietitian documented Resident #9 triggered for a significant weight loss of 10.8 lbs. in one month that was unplanned and undesirable following a weight gain of 8.9 lbs. The RD noted she met with the resident who stated that he can feed himself but sometimes had trouble getting food/utensil up to his mouth. The goals listed included weight stabilization and meal intake greater than 50% for three meals. On 12/11/24 the RD documented Resident #9 triggered for a significant weight loss of 14.8 lbs. in three months that was unplanned and undesirable likely related to variable intake/fair appetite. The resident reported having a fair appetite. He generally does well with breakfast. The resident also felt like his current weight was not accurate. He reported having difficulty reaching the plate on the bedside table tray. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/13/24 the RD documented a reweight was obtained and showed a 19.4 lbs. weight loss in one week. Per the interdisciplinary team, the resident was to have one to one feedings, he was a dependent eater. Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 12/16/24 noted Resident #9's weight was 156 lbs. The MDS coordinator checked no or unknown for weight loss of 5% or more in the last month. On 12/18/24 the RD documented the resident continued to have a poor appetite, generally consuming one meal per day. Order for mirtazapine (antidepressant that can be used for appetite stimulant). The resident's weight was 155.8 lbs. The RD noted the resident had a significant weight loss documented on 12/11/24 and 12/13/24. The interventions included to increase fortified foods to all meals, add snack twice a day. Review of the resident's meal intake for December 2024 showed no meal intake documented for breakfast or lunch on 12/2/24, 12/5/24, 12/6/24, 12/7/24, 12/8/24, 12/9/24, 12/10/24, 12/11/24, 12/16/24, 12/22/24, 12/24/24, 12/26/24, 12/28/24, 12/29/24, 12/30/24, and 12/31/24. The meal percentage was not documented for dinner on 12/22/24. On 1/9/25 at 8:15 p.m., Resident #9's dinner was observed uneaten on a meal cart across from the nurse's station. On 1/9/25 at 8:24 p.m., in an interview Unit Manager Licensed Practical Nurse Staff I verified Resident #9 did not eat his dinner meal. She said a couple of weeks ago, she notified the physician of the resident's poor appetite. The physician ordered mirtazapine 7.5 milligrams at bedtime for appetite stimulant. The Unit Manager said the Certified Nursing Assistants were supposed to document meal intakes and notify her when a resident refused a meal. On 1/9/25 at 8:30 p.m., Unit Manager Staff I looked at the meal intake documentation and verified the CNAs were not consistently documenting the percentage of meals for Resident #9. She verified no meal intake was entered for dinner for 1/9/25 and no one notified her the resident refused dinner. She said without consistent and accurate documentation of meal intakes, it was not possible to determine the effectiveness of the appetite stimulant. The Unit Manager provided a list of weight for January 2025. Resident #9's weight was listed as 141.2 lbs. A review of the Center for Medicare and Medicaid Services Roster/Sample Matrix form (used to document residents relevant care categories) failed to identify Resident #9's excessive weight loss without a prescribed weight loss program. On 1/9/25 at 8:40 p.m., in an interview the DON said she was not aware the CNAs were not consistently documenting meal intakes. She did not know why Resident #9's excessive weight loss was not captured on the Roster Matrix. She said the nurses were supposed to ensure the meal percentage was documented before the CNA leaves. The Unit Managers supervise the nurses and the Assistant Director of Nursing (ADON) supervises the Unit Managers. The DON said she did not review the CNAs or the nurse's documentation unless a problem is reported to her. (continued on next page)

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