STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105394	A. Building B. Wing	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at the Palms	2600 Highlands Blvd N Palm Harbor, FL 34684

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 43453 Based on observations, record review of the Facility Assessment, policies and procedures, job descriptions, and clinical records, and interviews with facility staff, the Medical Director (MD), the facility Advanced Practice Registered Nurse (APRN), a Family Member, and a resident, the facility neglected to provide the care and services to prevent an unwitnessed exit from the facility for one (Resident #129) of 10 sampled residents reviewed for high risk elopement. The facility neglected to notify Resident #129's physician and family of escalating exit-seeking behaviors, failed to obtain physician orders for a wanderguard (electronic monitoring device), failed to assess the possible reason for exit seeking behaviors in order to put meaningful interventions in place, failed to provide one to one supervision as directed by the Director of Nursing (DON), failed to place Resident #129's picture and physical description information in the elopement books, failed to implement the person-centered care plan, and failed to identify risks in the physical environment of a faulty exit gate in the enclosed courtyard area. Resident #129 was a newly admitted resident who was unfamiliar with his environment. He was assessed as a high risk for elopement with multiple attempts to exit the facility and had diagnoses of encephalopathy, anoxic brain damage, generalized anxiety disorder, insomnia, alcohol and psychoactive substance abuse in remission, and a history of falling. On 04/16/22, Resident #129 exited the facility, unbeknownst to staff, through the courtyard area and was able to ambulate approximately 5 miles away from the facility, through heavy traffic alongside and across a highly traveled 8 lane divided highway with a speed limit of 55 mph. Resident #129 was last seen by facility staff around 3:00 PM on 04/16/22. Staff were unable to locate the resident and contacted the Police to assist in the search on 04/16/22 around 4 PM. The Police contacted the facility on 04/16/22 around 7 PM to let them know the resident was found and transferred to the hospital. Resident #129 was admitted to the hospital for 4 days and was treated for acute kidney injury, acute rhabdomyolysis, and acute generalized weakness, all of which were secondary to dehydration. The likelihood of serious physical harm or death to Resident #129 as a result of the facility's neglect resulted in findings of Immediate Jeopardy on 04/16/22, and removed on 04/22/22, with the scope and severity reduced to a D. Findings included: Cross Reference F689 (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a facility report revealed the facility started an investigation for possible neglect on 04/16/22. The report indicated that Resident #129 was last seen in the facility on 04/16/22 around 3:00 PM. The Director of Nursing (DON) was notified of this around 4:00 PM on 04/16/22. A complete search of the facility and surrounding areas was completed and staff was sent out by car. The Pinellas County Sheriff's Office (PCSO) was notified and arrived at the facility at approximately 4:05 PM. The report stated the Resident had no Representative/Family on file. A review of the Facility Assessment reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee on 3/21/22, revealed the facility accepts residents for admission that have psychiatric/mood disorders and neurological system diseases/conditions to include common diagnoses of Behavior that needs interventions. The facility provides services and care which include person-centered care: Psychosocial well-being support and building relationships with residents/getting to know him/her, engaging residents in conversation, finding out preferences and routines; what makes a good day; what upsets the resident and incorporating this information into the care planning process. The facility provides opportunities for social activities/life enrichment, preventing abuse and neglect, identifying hazards and risks for residents, and offering the resident and family caregivers to be involved in person-centered care planning and advance care planning. All residents complete a social history and evaluation on admission. Baseline assessments are completed for elopement to identify residents that could be at risk and care plans are developed to decrease risks/hazards. The staffing portion of the Facility Assessment revealed Staffing is adjusted based on specific resident needs. On occasion, we will have a need to place a resident on a one to one ratio. This is done when a resident has a difficult time transitioning, is and [sic] elopement risk, or a very significant fall risk . A review of a facility policy with a copyright date of 2021 titled, Abuse, Neglect and Exploitation revealed: Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, mistreatment including injuries of unknown origin and misappropriation of resident property. Facility policy is to report allegations and complete investigation of allegation. Definitions: . Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress . Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; . c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of resident property, reporting procedures, and dementia management and resident abuse prevention; . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a facility job description titled, Registered nurse (RN), dated April 2020 revealed a Summary: Provide direct nursing care to the residents and provide clinical oversight of the day-to-day nursing activities performed by Licensed Practical Nurses and or Certified Nursing Assistants . in accordance with current Federal, State, and Local standards, guidelines, and regulations that govern facility. Duties and Responsibilities included: Ensure nursing personnel assigned to you comply with written policies and procedures; Meet with your assigned nursing staff, . in planning the shifts services .; Cooperate with other resident services when coordinating nursing services and be certain that the resident's total regimen of care is maintained; Work with physicians .to review treatment plans .; Received telephone orders from physicians . ; Document in electronic health record (EHR) in an informative and descriptive manner that reflects the care provided to the resident, as well as the resident's response to care following established facility charting and documentation policies; . assist with other resident needs; Consult with the resident's physician in providing the resident's care, treatment .as necessary; Make periodic rounds to confirm that care and services are being properly administered by LPNs, CNAs . to evaluate the resident's physical and emotional status; Notify the resident's attending physician when the resident is involved in an accident or incident or when there is a change in the resident's condition; Review care plans to confirm that appropriate care is being rendered; Confirm that LPN's and CNA's are aware of the resident care plans . Review of a facility job description titled, Certified Nursing Assistant (CNA), dated April 2020 revealed Summary: Perform direct resident care duties under the supervision of licensed nursing personnel. Assist with promoting compassionate physical and psychosocial environment for the residents . Duties and Responsibilities included observe residents carefully and report changes in condition to Charge Nurse. An interview was conducted on 04/19/22 at 5:09 PM with the Admissions Director. The Admissions Director stated he first received the referral paperwork for Resident #129 in early March of 2022 from a hospital located in Jacksonville. The Admissions Director stated it took over a month to review and assess if Resident #129 was appropriate for admission. The Admissions Director reported his primary diagnoses from the hospital was altered mental status and anoxic brain injury, and the hospital had notified him that the resident wandered. The Admissions Director said, they [the referring hospital] said he did not need a secure unit, but he would be okay with an electronic monitoring device. The Admissions Director stated the elopement risk did not present outside of the normal admission criteria. The Admissions Director stated an electronic monitoring device was put on Resident #129, on Friday, 4/15/22 (the day of admission), because he was observed wandering around and was exit seeking. The Admissions Director stated he sent out a notification to the Nursing Home Administrator (NHA), Director of Nursing (DON), all Department heads, and the nursing staff that he was a wander risk on Friday morning (04/15/22) prior to the resident's arrival. The Admissions Director provided a copy of the notification sent prior to admitting the resident, which indicated the resident might need a wanderguard. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/19/22 at 4:38 PM, the Social Services Director (SSD) stated he saw Resident #129 briefly when he assisted with smoke break supervision in the courtyard at 2 PM on Friday (4/15/22), the day the resident was admitted . The SSD stated Resident #129 presented confused and walked around looking for cigarette butts. The SSD stated Resident #129 was telling everyone that he didn't have any cigarettes. The SSD said, I did not address his anxiety. I know he wanted cigarettes. I should have gotten them for him. Normally when a resident does not have cigarettes, I'll go out and buy them cigarettes. The SSD stated he did not get a chance to establish a relationship with Resident #129. The SSD was observed to become tearful. The SSD stated he was emotional because he did not meet the resident's needs. The SSD stated he usually meets with new residents within the first couple of days they are admitted . The SSD stated his assessment of Resident #129 based on his observations was that he was coherent. He was telling people he just got out of prison. Resident #129 was able to make his needs known. Resident #129 did not show anger, just anxiety. The SSD stated Resident #129 was wandering around confused. The SSD stated he supervised him and other residents in the courtyard area for about 20 minutes and went back in the facility. The SSD confirmed he was aware Resident #129 was an elopement risk and the Admissions Director had stated that he probably needed an electronic monitoring device. The SSD confirmed that the Admissions Director had informed nurses on Friday, 4/15/22 and had also covered this with the department heads in several meetings prior to the resident's admission. The SSD stated if a resident was wandering and presenting elopement behaviors, the protocol was to call the physician and get an order for an electronic monitoring device. The SSD did not indicate that any special services or supervision were provided for residents presenting with active wandering and elopement behaviors. Review of Resident #129's clinical record revealed no Social Service Assessment or Social Service notes were completed prior to the resident eloping on 04/16/22. An interview was conducted on 04/21/22 at 11:25 AM with Staff V, an Agency Registered Nurse (RN). Staff V stated that she admitted Resident #129 around 1:45 PM on Friday, 04/15/22. Staff V stated she did not get a report on Resident #129 prior to his arrival. Staff V stated she reviewed the paperwork the resident arrived with, completed the admission assessments and physician orders. Staff V stated Resident #129 started wandering instantly. Staff V stated Resident #129 wanted to smoke and kept walking out of the room. Staff V stated she did not have an assessment of Resident #129's mental status but figured we needed to keep him from exiting the facility. Staff V stated Staff N, LPN/Unit Manager told her to put an electronic monitoring device on Resident #129. Staff V stated she put the device on Resident #129 on 04/15/22 because he wanted to go out. Staff V said, I kept chasing him around. Staff V stated she did not know the facility policy on wandering residents or electronic device application. Staff V said, I figured the Unit Manager had the orders in place. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the admission elopement evaluation dated 04/15/22 at 1:38 PM completed by Staff V revealed the resident's elopement score was 12. The form noted that a score of 11 or above indicated High Risk to Wander. A review of the skilled nursing evaluation also completed on 04/15/22 at 1:38 PM revealed resident was alert with some forgetfulness, wanders at night, sleeps intermittently, no restraints, alarms, or sensors were in place, resident/responsible party concerns were noted as possible wandering. A neurologic and mental status note indicated within normal limits (WNL), although resident has history of confusion at times. Continued review of the clinical record revealed no presence of notes related to the resident's continuous wandering, his desire to leave the facility, and/or placement of the wanderguard device on 04/15/22, the day he was admitted . Additionally, there was no physician order for the application of the wanderguard or orders to check for placement/function of the electronic monitoring device or notification to the physician of exit seeking behaviors prior to the elopement on 04/16/22. On 04/21/22 at 11:35 AM, Staff N, Licensed Practical Nurse (LPN)/Unit Manager confirmed she had worked on Friday 4/15/22 when Resident #129 was admitted . Staff N stated it was sometime early in the afternoon. Staff N stated she was covering both units that day and did not have any interaction with Resident #129. Staff N could not recall if she was notified the resident was an elopement risk. Staff N said, I might have. I was focused on another resident. Staff N said if a resident was displaying elopement behaviors, the expectation was to call the physician, get an order, and update the care plan. Staff N said, I should have made the call to the physician. I guess I should have. Friday was hectic. I was here until 4 or 5 PM. On 04/19/22 at 4:51 PM, Staff E, RN/Minimum Data Set (MDS) Coordinator revealed she reviewed Resident #129's diagnoses and history on 04/15/22, the day he was admitted . She stated that Resident #129 had been hospitalized in Jacksonville since November of 2021, was noted as at risk for wandering, was ambulatory, had a history of being homeless, and did not like to be confined. Staff E reported that she started Resident #129's baseline care plan but had no interaction with the resident that day. She stated that her counterpart, Staff D, RN/MDS Coordinator came in on Saturday, 04/16/22 to update the care plan for Resident #129. Staff E reported that she first heard about Resident #129's elopement when she returned to work on Monday, 04/18/22. Staff E stated in-servicing and mock elopement drills were started that Monday, 04/18/22. Staff E confirmed that there was no physician order for the application or monitoring of a wanderguard for Resident #129 and stated the Director of Nursing (DON) should have obtained the order. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 04/19/22 at 3:03 PM with Staff A, Certified Nursing Assistant (CNA). Staff A confirmed he was assigned to Resident #129 on 04/16/22 from 7 AM-3 PM. Staff A stated the first time he saw Resident #129. he noticed something was suspicious. Staff A reported he saw Resident #129 exit his bedroom around 1 PM, his body language was odd. When asked to describe what he meant by odd, Staff A stated, he was looking like he had a purpose or plan to escape. Staff A stated Resident #129 was carrying his personal bag, walking down hall 300 towards the front lobby exit door of the facility. Staff A stated he did not ask Resident #129 where he was going at first. Staff A indicated he wanted to see where Resident #129 was going and watched him for about 30 minutes while also attending to other residents. Staff A said, I assumed he was going to elope because he was hanging out by the front door. Staff A stated the resident kept going back and forth between the front lobby exit door and the 300 nurses' station. Staff A stated another CNA, Staff F, was about to let Resident #129 exit out the front of the building because Staff F thought Resident #129 was a guest. Staff A stopped Staff F from letting the resident out and redirected Resident #129 to his room. Staff A stated Resident #129 was high functioning and he presented as a guest even though he had slurred speech and was difficult to understand. Staff A stated Resident #129 repeatedly said he was just nervous and did not want to be at the facility. Staff A stated Resident #129 wanted to smoke, but did not have cigarettes. Staff A stated he attempted to find out why the resident wanted to leave, but the resident did not provide any specifics as to why or where he wanted to go but continued to verbalize wanting to leave. Staff A suggested to Resident #129 to wait till Monday to speak to the Social Services Director (SSD). Staff A stated he notified Staff B, the Agency Licensed Practical Nurse (LPN) assigned to Resident #129, and the Director of Nursing (DON), who was in the building, that Resident #129 was attempting to elope. Staff A stated the DON agreed Resident #129 was an elopement concern and told Staff A to keep an eye on the resident as they would probably put him on 1:1 supervision. Staff A reported he received a phone call on 04/16/22 around 1 PM from Staff L, the Staffing Coordinator, and was asked to tell Staff C, C.N.A., to provide 1:1 supervision for Resident #129. Staff A stated he continued to watch Resident #129 and tended to his other residents while Staff C was on her lunchbreak. Staff A stated he saw Resident #129 grab his bag and exit through the 400 hall door to the enclosed exterior courtyard/gazebo area. The resident walked through the courtyard and re-entered the facility through the dining room door and then went to the front lobby area around 1:30 PM. Staff A reported that he saw Staff D, Registered Nurse (RN)/Minimum Data Set (MDS) Coordinator, stopping Resident #129 at the front lobby exit door attempting to leave, yet again. Staff A confirmed that Resident #129 was not listed in the elopement book (a binder maintained in the front lobby and at the nurses stations with photos and physical descriptions of residents assessed as high risk for wandering and elopement), but reported that the resident had an electronic monitoring device on that entire day. Staff A said, I did not check it [the electronic monitoring device]. I do not know if it was functioning. Staff A said he saw Resident #129 attempting to leave again about 20-25 minutes later. Staff A stated on 04/16/22 at about 2:45 PM, he checked on Resident #129 and found him just standing in his room. Staff A stated he last saw Resident #129 at the end of his shift (3 PM) in the courtyard picking up sticks. Staff A thought Resident #129 was just keeping busy. Staff A confirmed there was no staff with the resident in the courtyard. Staff A stated supervision was required for residents who are exit seeking. Staff A said, He should have had supervision, for sure from 1pm and 3pm. Staff A stated he could not confirm the exact time the DON established the 1:1 supervision. Staff A stated they did not have a 1:1 supervision log for that day. Staff A stated the expectation for 1:1 supervision was to visually keep an eye on the resident and to try to redirect. Staff A stated he did not speak to the on-coming shift about Resident #129's wandering concerns before he left at 3 PM on 04/16/22 because he thought Staff C was going to be providing 1:1 supervision. Staff A stated from his assessment, Resident #129 probably pulled himself over the gate in the courtyard. Staff A stated the gate was not alarmed and the electronic monitoring device would not activate on that gate. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 4/19/22 at 4:05 PM with Staff D, RN/MDS Coordinator. Staff D stated she came in to work on Saturday morning (04/16/22) and saw Resident #129 in the front lobby area around 10 AM. Staff D stated she had not met him prior to this as he was admitted the day before (04/15/22). She noticed he was carrying a reusable shopping bag and looked like a visitor. Staff D stated she asked Resident #129 if he was wanting to exit the facility. Staff D stated she was about to let the resident out of the building when, The Receptionist [Staff R] told me he was a resident. I redirected him to his room. Staff D stated Resident #129 was moderately built, steady, healthy, presented content but confused. Staff D stated Resident #129 looked confused as he headed to his room. Staff D stated she was notified that they had already placed an electronic monitoring device on the resident. Staff D stated she started the elopement care plan and in the special instructions section noted, wanders/elopement risk so everyone would know. Staff D stated Resident #129 was not in the elopement book. Staff D did not know who takes the photos and places them in the elopement book. Staff D said, In hindsight, I should have done it then. I should have put him in the elopement book and brought a copy to all units. Staff D stated throughout the day, Resident #129 was observed in the smoking courtyard area or the front lobby area. Staff D stated that was concerning because these areas are target exits. Staff D stated she last saw Resident #129 on 04/16/22 at 2 PM talking to another resident (Resident #74). Staff D stated the next thing she heard was the announcement that was made shortly after 4 PM on 04/16/22. Staff D stated Staff B announced, Attention staff, Mr. [Resident #129] report to your room. Staff D reported this was repeated three times. Staff D reported to the nurse's station and heard that Resident #129 was last seen on 04/16/22 at 3 PM. Staff D verified that the interior of the facility was searched, and she drove her car around the parameter of the facility, searched around a strip mall area and gas station approximately 1/2 a mile from the facility and could not locate the resident. Staff D stated she saw other staff looking for the resident, and they had traveled North on U.S. Highway 19. Staff D stated the Police, Director of Nursing (DON) and Assistant Director of Nursing (ADON) were at the facility when she returned. Staff D stated the DON had her verify the electronic monitoring devices and care plans for Resident #129. Staff D stated as she reviewed Resident #129's physician orders, she noticed there was no order for an electronic monitoring device. Staff D stated the transcription for an order was to be done as soon as an order was given. Staff D stated she could not confirm if the nurse who placed the device on the resident had ever received a verbal physician's order. Staff D stated I should have looked at that and spoken to the nursing staff. Staff D stated she stayed at the facility and reviewed other residents at risk for elopements care plans and physician orders until the police officer came and let them know that Resident #129 had been located, which was probably between 7 PM and 7:30 PM on 04/16/22. Staff D stated she heard Resident #129 was found at a local supermarket somewhere off U.S. Highway 19 North. Staff D stated that on Monday, 04/18/22, there was follow-up education by nursing. The education consisted of reviewing the elopement policies, updating elopement books and how to print pictures of residents, and reviewing elopement scores. A review of Resident #129's clinical record revealed a care plan was developed by Staff D, MDS Coordinator on 04/16/22 for a risk of elopement/exit seeking aimlessly, wandering due to cognition and has the potential to approach exit doors. The goal, with a target date of 7/14/22, was Resident #129 will not leave the facility unattended. Interventions included: Approach in a calm manner. Assess for psychological causes. Check functioning/placement of wanderguard every shift. (continued on next page)

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	105394	A. Building B. Wing	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at the Palms	2600 Highlands Blvd N Palm Harbor, FL 34684

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Evaluate unit for possible safety hazards. Facilitate resident to call close family/friend for reassurance when exit seeking behaviors occur. Monitor resident for tailgating when visitors are in the building. Reassure resident when distressed over placement. Refer to Social Services as needed. Seek a referral for a mental health evaluation from primary care physician as needed. Use diversional activities when exit-seeking behavior is occurring (i.e.: offer food, activities, one-on-one company). Review of Resident #129's clinical record revealed no evidence that these interventions were implemented prior to Resident #129's elopement on 04/16/22. On 04/20/22 at 1:41 PM, an interview was conducted with Resident #129's Family Member who was also listed as the Emergency Contact on Resident #129's Admission Record (face sheet) and also listed on two hospital patient transfer forms (Form 3008) dated 2/14/22 and 4/14/22. These transfer forms were in Resident #129's admission paperwork that accompanied him from the referring hospital in Jacksonville, FL on 04/15/22. The Family Member's name and telephone number were listed on all forms. Resident #129's Family Member stated she was not notified about the elopement by the facility nor had anyone from the facility made any attempts to contact her to discuss the resident's needs or history. She stated that the hospital called her on 04/19/22 to no [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37999 Based on observations, record reviews, and interviews the facility failed to ensure an allegation of mishandling of a fracture was reported to state agencies for one (#40) of three residents reviewed for abuse. Findings included: A review of a facility policy with a copyright date of 2021 titled, Abuse, Neglect and Exploitation revealed: Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, mistreatment including injuries of unknown origin and misappropriation of resident property. Facility policy is to report allegations and complete investigation of allegation. Definitions: . Abuse means the willful infliction of injury .resulting in physical harm, pain, or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Injuries of Unknown Origin/Source means an injury of unknown origin when BOTH of the following are met: 1. The origin or source of the injury is unobserved and cannot be explained AND 2. The injury is suspicious because of the extent or location. VII. Reporting/Response A. Reports of suspected abuse, neglect, exploitation, mistreatment, .shall be reported: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within the specified timeframes: a. Immediately, but not 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 b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Complete Immediate Federal Report within 2 hours of alleged abuse or neglect with harm. Review of Resident #40's admission record revealed an admitted in 2019 and diagnoses to include unspecified paraplegia, vascular dementia without behavioral disturbance, and polyneuropathy in disease classified elsewhere. Review of a significant change Minimum Data Set (MDS) assessment, dated 3/16/22, identified a Brief Interview of Mental Status score of 15, indicating intact cognition. On 4/18/22 at 3:30 p.m., Resident #40 reported that an agency aide had broken his left leg by mishandling it. The resident reported that the facility had been informed and that the aide had not worked with him since. The resident was observed with a walking boot on the left lower extremity (LLE). On 4/21/22 at 2:09 p.m., Resident #40 stated that the incident regarding the LLE occurred around August last year (2021) and that the physician and Director of Nursing (DON) at the time were notified of the aide breaking his left leg. The resident stated that after the occurrence the physician had told him he could take the boot off. A couple agency aides were not careful when moving the leg. The break had been straight but after that, the break was displaced and had healed in an x configuration. The resident stated he would clarify the incident as mishandling and did not feel it was intentional. Abuse no, mishandling yes. Resident #40 reiterated that the DON knew about the incident of mishandling but was no longer employed by the facility anymore. A review of the facility's incident log revealed no evidence of Resident #40's allegation of abuse, mishandling, or any other incident involving the resident. A provider follow-up note, dated 9/13/21, indicated the reason for the visit was due to a worsening tibia/fibula (tib/fib) fracture. The note reported that the provider was in to re-address follow-up X-ray findings that show worsening displacement of the LLE fracture and that the resident remembered no specific injury but noted edema of the left fracture when returning from a Leave of Absence (LOA). During the visit the provider noted that the resident was positioned in such a way that I was unable to remove the boot safely in order to examine the distal LLE. The provider identified an increased angulation and displacement of the fracture despite a walking boot being in place. The provider indicated that the resident could not recall any movements that would have worsened the fracture. The report of the LLE fracture identified osteopenia. The note identified the following Lab/Imaging Results: - 8/1/21: Left ankle Anterior-Posterior (AP) and lateral (lat) - 2 views, with findings of no dislocation or destructive bony process. Osteopenia. Acute distal tibia and fibular shaft fracture with moderate soft tissue swelling. - 9/10/21: Left Tibia/Fibula AP and Lat comparison. Worsening apex posterior angulation of the known distal tibial and fibular fractures with partial interval progression towards healing. The assessment/plan indicated that it appeared to be related to severe osteopenia, now had worsened angular displacement but some signs of healing, and was an unknown injury but appeared to occur during LOA on July 23-25 (2021). (continued on next page)

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	105394	A. Building B. Wing	04/22/2022

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Interim DON stated, on 4/21/22 at 3:18 p.m., that she was not Resident #40's nurse at the time but from what she could remember, the resident broke his leg while on a LOA. A review was conducted of the worsening fracture of the tibula/fibula of Resident #40 with the Interim DON. She stated that the DON at the time of the event had been at the facility for more than a couple of months. The Interim and Regional DON stated that if the allegation was made that an aide had mishandled the resident's leg there should have been a full investigation. During an interview on 4/21/22 at 3:34 p.m., the Nursing Home Administrator (NHA) reported that there was no evidence that Resident #40's LLE injury was reported. The NHA was not working at the facility when these injuries were said to have occurred.

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	105394	A. Building B. Wing	04/22/2022

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 37999 Based on observations, record reviews, and interviews the facility failed to ensure an allegation of mishandling of a fracture was investigated for one (#40) of three residents reviewed for abuse. Findings included: A review of a facility policy with a copyright date of 2021 titled, Abuse, Neglect and Exploitation revealed: Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, mistreatment including injuries of unknown origin and misappropriation of resident property. Facility policy is to report allegations and complete investigation of allegation. Definitions: . Abuse means the willful infliction of injury .resulting in physical harm, pain, or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Injuries of Unknown Origin/Source means an injury of unknown origin when BOTH of the following are met: 1. The origin or source of the injury is unobserved and cannot be explained AND 2. The injury is suspicious because of the extent or location. V. Investigation of Alleged Abuse, Neglect and Exploitation A. When an incident of suspected mistreatment, neglect, or abuse, sexual misconduct, including injuring of unknown origin and misappropriation of resident property an immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigation include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation. 3. Investigating different types of violations; (continued on next page)

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	105394	A. Building B. Wing	04/22/2022

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. Review of Resident #40's admission record revealed an admitted in 2019 and diagnoses to include unspecified paraplegia, vascular dementia without behavioral disturbance, and polyneuropathy in disease classified elsewhere. Review of a significant change Minimum Data Set (MDS) assessment, dated 3/16/22, identified a Brief Interview of Mental Status score of 15, indicating intact cognition. On 4/18/22 at 3:30 p.m., Resident #40 reported that an agency aide had broken his left leg by mishandling it. The resident reported that the facility had been informed and that the aide had not worked with him since. The resident was observed with a walking boot on the left lower extremity (LLE). On 4/21/22 at 2:09 p.m., Resident #40 stated that the incident regarding the LLE occurred around August last year (2021) and that the physician and Director of Nursing (DON) at the time were notified of the aide breaking his left leg. The resident stated that after the occurrence the physician had told him he could take the boot off. A couple agency aides were not careful when moving the leg. The break had been straight but after that, the break was displaced and had healed in an x configuration. The resident stated he would clarify the incident as mishandling and did not feel it was intentional. Abuse no, mishandling yes. Resident #40 reiterated that the DON knew about the incident of mishandling but was no longer employed by the facility anymore. A review of the facility's incident log revealed no evidence of Resident #40's allegation of abuse, mishandling, or any other incident involving the resident. A provider follow-up note, dated 9/13/21, indicated the reason for the visit was due to a worsening tibia/fibula (tib/fib) fracture. The note reported that the provider was in to re-address follow-up X-ray findings that show worsening displacement of the LLE fracture and that the resident remembered no specific injury but noted edema of the left fracture when returning from a Leave of Absence (LOA). During the visit the provider noted that the resident was positioned in such a way that I was unable to remove the boot safely in order to examine the distal LLE. The provider identified an increased angulation and displacement of the fracture despite a walking boot being in place. The provider indicated that the resident could not recall any movements that would have worsened the fracture. The report of the LLE fracture identified osteopenia. The note identified the following Lab/Imaging Results: - 8/1/21: Left ankle Anterior-Posterior (AP) and lateral (lat) - 2 views, with findings of no dislocation or destructive bony process. Osteopenia. Acute distal tibia and fibular shaft fracture with moderate soft tissue swelling. - 9/10/21: Left Tibia/Fibula AP and Lat comparison. Worsening apex posterior angulation of the known distal tibial and fibular fractures with partial interval progression towards healing. (continued on next page)

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	105394	A. Building B. Wing	04/22/2022

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessment/plan indicated that it appeared to be related to severe osteopenia, now had worsened angular displacement but some signs of healing, and was an unknown injury but appeared to occur during LOA on July 23-25 (2021). The Interim DON stated, on 4/21/22 at 3:18 p.m., that she was not Resident #40's nurse at the time but from what she could remember, the resident broke his leg while on a LOA. A review was conducted of the worsening fracture of the tibula/fibula of Resident #40 with the Interim DON. She stated that the DON at the time of the event had been at the facility for more than a couple of months. The Interim and Regional DON stated that if the allegation was made that an aide had mishandled the resident's leg there should have been a full investigation. During an interview on 4/21/22 at 3:34 p.m., the Nursing Home Administrator (NHA) reported that there was no evidence that Resident #40's LLE injury was investigated. The NHA was not working at the facility when these injuries were said to have occurred.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observations, review of medical records and facility policies, and interviews with facility staff, the Medical Director (MD), a Family Member, and residents, the facility failed to provide supervision to prevent an unwitnessed exit from the facility for one (Resident #129) of 10 residents sampled for high risk elopement. Resident #129 was a newly admitted resident with diagnoses to include other encephalopathy, anoxic brain damage, generalized anxiety disorder, insomnia, alcohol and psychoactive substance abuse in remission, and a history of falling. Resident #129 was identified as a high elopement risk with an electronic monitoring device (wanderguard) placed on him without notification or orders from the physician. Resident #129 could ambulate independently and presented as a visitor to those who did not know him. On 04/16/22 between 3pm and 4pm, Resident #129 was unaccounted for after multiple elopements attempts earlier that day in which the resident was seen carrying his belongings in a bag. Resident #129 was left unsupervised in an enclosed outdoor courtyard with a faulty exit gate. Resident #129 either jumped over the 6 foot gate or pushed the faulty gate open and was able to ambulate approximately 5 miles away from the facility, through heavy traffic alongside and across a highly traveled 8 lane divided highway with a speed limit of 55 mph. Facility staff drove around the neighborhood surrounding the facility and searched within the facility, but could not locate the resident and notified the authorities. Police contacted the facility around 7pm on 04/16/22 having located Resident #129 at a grocery store approximately 5 miles from the facility. Resident #129 was hospitalized post incident from 04/16/22 to 04/20/22 where he was treated for acute kidney injury, acute rhabdomyolysis, and acute generalized weakness all of which were secondary to dehydration. The likelihood of serious physical harm or death to Resident #129 as a result of the facility's failure to provide adequate supervision to prevent the elopement resulted in findings of Immediate Jeopardy on 04/16/22, and removed on 04/22/22, with the scope and severity reduced to a D. Findings included: Cross reference F600 Review of a Pinellas County Emergency Medical Services [EMS] Patient Care Report for Patient #129 revealed: EMS received a call on 4/16/22 at 18:07 (6:07 PM) EMS arrived at the scene on 4/16/22 at 18:29 (6:29 PM) (continued on next page)

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	105394	A. Building B. Wing	04/22/2022

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The narrative section of the Patient Care Report revealed EMS was called to a parking lot for a male who was found wandering the streets and was sitting outside a grocery store in Tarpon Springs. Pinellas County Sheriff's Office (PCSO) said that the patient is confused and appears to have eloped from his assisted living facility this morning in Palm Harbor. Staff confirmed patient is from Orchid Cove and has been missing since lunchtime. Patient has not voiced complaints. Police Department (PD) said that patient's Heart Rate (HR) is in the 140's but his BP is normal. Per PD, patient at first didn't want any treatment. Per PD, patient appears to have a history of dementia. Patient says he is from Jacksonville, Florida and is currently homeless. Pt was found sitting on the curb in a parking lot with PD and PCSO. Patient was alert with a Glasgow Coma Scale (GCS) of 14 at this time. Patient is unsteady on his feet and is at risk of falling. Patient's HR was sustained at 120 during transport. Pt kept moving his arms and EMS was unable to obtain his blood pressure (BP) during the 2 minute transfer to the emergency room (ER). Patient has a strong radial post. All other findings as noted. Patient to local hospital for evaluation of dehydration. A review of the hospital emergency room record revealed the patient was seen on 04/16/22 at 7:05 PM. The history of present illness (HPI) revealed Patient is a [AGE] year-old male who presents to the emergency department by emergency medical services (EMS). Patient has reportedly eloped from a nursing home facility this afternoon where he is a known flight risk, is still wearing an ankle monitor. Patient has been reportedly missing since around 1530 [3:30 PM] . He has apparently been walking around the area all afternoon. Patient states that he intends to walk to Fort [NAME] and then to Jacksonville . Patient is confusional, appears to have underlying dementia, and although he is able to answer some questions appropriately, is not oriented to time or situation . Patient complains of his feet aching . A physical exam of his skin revealed Patient appears to have erythema to his exposed forearms, neck, and face, consistent with sunburn . On physical examination, the patient's feet are cracked, appeared irritated and socks are very sweaty, but no indication of infection, no obvious injury . Review of Resident #129's hospital discharge summary dated 04/20/22, revealed a date of admission of 04/16/22 and date of discharge of 04/20/22. The discharge diagnosis revealed acute generalized weakness, suspect secondary to dehydration, acute rhabdomyolysis likely secondary to dehydration, acute kidney injury likely secondary to dehydration, Elevated CPK (Creatine Phosphokinase) level secondary to rhabdomyolysis, cognitive impairment, history of anoxic brain injury, and history of alcohol and amphetamine use. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Google Maps revealed the location where the police and EMS located Resident #129 was approximately 4.9 miles from the facility. Observation of the most direct route to this location from the facility on Saturday, 04/23/22 at approximately 5:30 PM, revealed Resident #129 would have traveled approximately 0.1 miles along a 2 lane limited access road (Highlands Blvd North) in front of the facility with a speed limit of 30 miles per hour (MPH). The resident would have then traveled North on US Highway 19 for approximately 2.4 miles. US Highway 19 is a highly traveled 8 lane divided highway with additional turning lanes and a speed limit of 55 MPH. US Highway 19 was observed to have sidewalks along both sides of the highway. In order for the resident to get to the location where he was found, he would have needed to cross the 8 lane highway. It is unknown where Resident #129 crossed the highway and if he used a crosswalk when crossing. Continuing along this direct route, Resident #129 would have then traveled on [NAME] Road for approximately 1.3 miles. This is a 4 lane divided roadway with sidewalks and a speed limit of 40 MPH. The resident would have then traveled to Pinellas Avenue (also known as Alternate US-19). The resident would have likely traveled approximately 1 mile on this 2 lane road with turning lanes and sidewalks and speed limits ranging from 35-40 MPH. This road led to the grocery store parking lot and intersection where Resident #129 was located. Review of the weather (www.wunderground.com) on 04/16/22 revealed the temperatures were noted as: 2:53 PM: 83 degrees Fahrenheit (F) with Humidity (H) of 65% 3:53 PM: 85 F; H 61% 4:53 PM: 86 F; H 48% 5:53 PM: 83 F; H 60% 6:53 PM: 79 F; H 72% Observation of the facility front entrance/lobby area on 04/18/22 at approximately 9:00 a.m. revealed no residents or guests could enter or exit the facility through the front entrance without a staff member entering a code on a keypad located just inside of the exit/entry door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 4/19/22 at 4:05 PM with Staff D, Registered Nurse (RN)/Minimum Data Set (MDS) Coordinator. Staff D stated she came in to work on Saturday morning (04/16/22) and saw Resident #129 in the front lobby area around 10 AM. Staff D stated she had not met him prior to this as he was admitted the day before (04/15/22). She noticed he was carrying a reusable shopping bag and looked like a visitor. Staff D stated she asked Resident #129 if he was wanting to exit the facility. Staff D stated she was about to let the resident out of the building when, The Receptionist [Staff R] told me he was a resident. I redirected him to his room. Staff D stated Resident #129 was moderately built, steady, healthy, presented content but confused. Staff D stated Resident #129 looked confused as he headed to his room. Staff D stated she was notified that they had already placed an electronic monitoring device on the resident. Staff D stated she started the elopement care plan and in the special instructions section noted, wanders/elopement risk so everyone would know. Staff D stated Resident #129 was not in the elopement book (a binder maintained in the front lobby and at the nurses stations with photos and physical descriptions of residents assessed as high risk for wandering and elopement). Staff D did not know who takes the photos and places them in the elopement book. Staff D said, In hindsight, I should have done it then. I should have put him in the elopement book and brought a copy to all units. Staff D stated throughout the day, Resident #129 was observed in the smoking courtyard area or the front lobby area. Staff D stated that was concerning because these areas are target exits. Staff D stated she last saw Resident #129 on 04/16/22 at 2 PM talking to another resident (Resident #74). Staff D stated the next thing she heard was the announcement that was made shortly after 4 PM on 04/16/22. Staff D stated Staff B announced, Attention staff, Mr. [Resident #129] report to your room. Staff D reported this was repeated three times. Staff D reported to the nurse's station and heard that Resident #129 was last seen on 04/16/22 at 3 PM. Staff D verified that the interior of the facility was searched, and she drove her car around the parameter of the facility, searched around a strip mall area and gas station approximately 1/2 a mile from the facility and could not locate the resident. Staff D stated she saw other staff looking for the resident, and they had traveled North on U.S. Highway 19. Staff D stated the Police, Director of Nursing (DON) and Assistant Director of Nursing (ADON) were at the facility when she returned. Staff D stated the DON had her verify the electronic monitoring devices and care plans for Resident #129. Staff D stated as she reviewed Resident #129's physician orders, she noticed there was no order for an electronic monitoring device. Staff D stated the transcription for an order was to be done as soon as an order was given. Staff D stated she could not confirm if the nurse who placed the device on the resident had ever received a verbal physician's order. Staff D stated I should have looked at that and spoken to the nursing staff. Staff D stated she stayed at the facility and reviewed other residents at risk for elopements care plans and physician orders until the police officer came and let them know that Resident #129 had been located, which was probably between 7 PM and 7:30 PM on 04/16/22. Staff D stated she heard Resident #129 was found at a local supermarket somewhere off U.S. Highway 19 North. Staff D stated that on Monday, 04/18/22 there was follow-up education by nursing. The education consisted of reviewing the elopement policies, updating elopement books and how to print pictures of residents, and reviewing elopement scores. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105394	A. Building B. Wing	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at the Palms	2600 Highlands Blvd N Palm Harbor, FL 34684

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 04/19/22 at 3:03 PM with Staff A, Certified Nursing Assistant (CNA). Staff A confirmed he was assigned to Resident #129 on 04/16/22 from 7 AM - 3 PM. Staff A stated the first time he saw Resident #129 he noticed something was suspicious. Staff A reported he saw Resident #129 exit his bedroom around 1pm, his body language was odd. When asked to describe what he meant by odd, Staff A stated, he was looking like he had a purpose or plan to escape. Staff A stated Resident #129 was carrying his personal bag, walking down hall 300 towards the front lobby exit door of the facility. Staff A stated he did not ask Resident #129 where he was going at first. Staff A indicated he wanted to see where Resident #129 was going and watched him for about 30 minutes while also attending to other residents. Staff A said, I assumed he was going to elope because he was hanging out by the front door. Staff A stated the resident kept going back and forth between the front lobby exit door and the 300 nurses' station. Staff A stated another CNA, Staff F was about to let Resident #129 exit out the front of the building because Staff F thought Resident #129 was a guest. Staff A stopped Staff F from letting the resident out and redirected Resident #129 to his room. Staff A stated Resident #129 was high functioning and he presented as a guest even though he had slurred speech and was difficult to understand. Staff A stated Resident #129 repeatedly said he was just nervous and did not want to be at the facility. Staff A stated Resident #129 wanted to smoke, but did not have cigarettes. Staff A stated he attempted to find out why the resident wanted to leave but the resident did not provide any specifics as to why or where he wanted to go but continued to verbalize wanting to leave. Staff A suggested to Resident #129 to wait till Monday to speak to the Social Services Director (SSD). Staff A stated he notified Staff B, the Agency Licensed Practical Nurse (LPN) assigned to Resident #129 and the Director of Nursing (DON), who was in the building, that Resident #129 was attempting to elope. Staff A stated the DON agreed Resident #129 was an elopement concern and told Staff A to keep an eye on the resident as they would probably put him on 1:1 supervision. Staff A reported he received a phone call on 04/16/22 around 1 PM from Staff L, the Staffing Coordinator and was asked to tell Staff C, CNA, to provide 1:1 supervision for Resident #129. Staff A stated he continued to watch Resident #129 and tended to his other residents while Staff C was on her lunchbreak. Staff A stated he saw Resident #129 grab his bag and exit through the 400 hall door to the enclosed exterior courtyard/gazebo area. The resident walked through the courtyard and re-entered the facility through the dining room door and then went to the front lobby area around 1:30 PM. Staff A reported that he saw Staff D, Registered Nurse (RN)/Minimum Data Set (MDS) Coordinator, stopping Resident #129 at the front lobby exit door attempting to leave, yet again. Staff A confirmed that Resident #129 was not listed in the elopement book, but reported that the resident had an electronic monitoring device on that entire day. Staff A said, I did not check it [the electronic monitoring device]. I do not know if it was functioning. Staff A said he saw Resident #129 attempting to leave again about 20-25 minutes later. Staff A stated on 04/16/22 at about 2:45 PM, he checked on Resident #129 and found him just standing in his room. Staff A stated he last saw Resident #129 at the end of his shift (3 PM) in the courtyard picking up sticks. Staff A thought Resident #129 was just keeping busy. Staff A confirmed there was no staff out in the courtyard at that time. Staff A stated supervision was required for residents who are exit seeking. Staff A said, He should have had supervision, for sure from 1pm and 3pm. Staff A stated he could not confirm the exact time the DON established the 1:1 supervision. Staff A stated they did not have a 1:1 supervision log for that day. Staff A stated the expectation for 1:1 supervision was to visually keep an eye on the resident and to try to redirect. Staff A stated he did not speak to the on-coming shift about Resident #129's wandering concerns before he left at 3 PM on 04/16/22 because he thought Staff C was going to be providing 1:1 supervision. Staff A stated from his assessment, Resident #129 probably pulled himself over the gate in the courtyard. Staff A stated the gate was not alarmed and the electronic monitoring device would not activate on that gate. (continued on next page)

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	105394	A. Building B. Wing	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at the Palms	2600 Highlands Blvd N Palm Harbor, FL 34684

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An observation was made of the courtyard/gazebo area with Staff A immediately following the interview. The 400 hall door and the Dining Room door both exit to the enclosed courtyard/gazebo area. These doors do not alarm or require keypad access in order to enter or exit. Black colored scuff marks were observed on the white courtyard exit gate. The marks were noted to be in the shape of a shoe print. The shoe print marks were also observed on a blue electrical box on the left side of the gate. Staff A stated Resident #129 most likely stepped on the electrical box and pulled himself up over the fence in order to exit the facility. Photographic evidence was obtained. The facility had a staff member stationed in the courtyard area to supervise residents and observe the exit gate. Staff A stated this was put in place after Resident #129's elopement. On 04/19/22 at 2:34 PM, Staff C, CNA was observed seated in the courtyard area and stated she was watching the exit gate because they suspected Resident #129 eloped by going over the gate. Staff C confirmed staff have been watching the gate since Saturday night (04/16/22) because they don't know if it is secure. Staff C stated she first met Resident #129 on Saturday (4/16/22). Staff C was assigned light duty on 04/16/22, to include smoking supervision. Staff C reported that she was scheduled to work a double shift on 04/16/2022 (7AM-3PM and 3PM-11PM). Staff C stated she first saw Resident #129 during a smoke break on 04/16/22 around 11 AM. Staff C stated, Resident #129 was outside most of the afternoon and was in and out of the building with residents who smoke all day. Staff C stated she did not think Resident #129 had cigarettes even though he wanted to smoke. Staff C stated she last saw Resident #129 around 3 PM when obtaining his vitals and passing ice water. Staff C stated Resident #129 appeared restless and had an electronic monitoring device on. Staff C stated when a new resident comes in and they become actively exit seeking, they put an electronic device on them. Staff C stated that she heard from Staff A that Resident #129 had tried to get out and Staff B, LPN was notified. Staff C said, I was planning to do 1 to 1 supervision per [Staff A], then the nurse [Staff B] said that it was not necessary. The nurse [Staff B] asked me to pass ice instead of the 1 to 1 supervision. Staff C said, From my understanding, if the nurse felt it was necessary, she should have put him on a 1 to 1. Staff C stated Resident #129 was not put on 1:1 supervision because a receptionist (Staff R) was watching the front door. Staff C stated residents on electronic monitoring devices require supervision. We check equipment for placement and functionality and to know where the resident is throughout the day. Staff C stated it was the responsibility of the resident's assigned CNA along with the nurse and other staff. Staff C stated when Resident #129 was confirmed missing, it was around 4 PM. Staff C said, No one had seen him for about one hour or so. I went around the building and then got in the car and drove around, went up and down US Highway 19 and was looking at least an hour and half. Staff C stated Resident #129 was not found and she returned to the facility. (continued on next page)

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	105394	A. Building B. Wing	04/22/2022

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Aspire at the Palms	2600 Highlands Blvd N Palm Harbor, FL 34684

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was conducted on 04/20/22 at 10:02 AM with Staff B, Agency LPN. Staff B confirmed she had worked a double shift on 04/16/22, 7 AM-3 PM and 3 PM-11 PM. Staff B stated she was assigned to Resident #129 on both shifts. Staff B stated from the time she arrived that Saturday morning, Resident #129 kept wandering around and appeared forgetful. Staff B confirmed that a CNA almost let the resident out of the building because he thought the resident was a visitor. Staff B stated Resident #129 had an electronic monitoring device on and was hanging out by the front lobby exit door. Staff B said, The fear was that he would run out the door. Staff B stated at some point, Resident #129 had packed his stuff and was walking around with a bag. Staff B said, It concerned me that he was walking around with the bag. I feared he might escape. Staff B stated she spoke to the DON about Resident #129's wandering behaviors, and the DON had said to put Resident #129 on 1 to 1 supervision. Staff B stated Staff C, C.N.A., was on light duty and was to provide the 1:1 supervision. Staff B stated around 1:30 PM she asked Staff C to do vitals for the 300 and 400 hall residents. Staff B stated there was a receptionist (Staff R) in the building who was to keep an eye on Resident #129. Staff B did not report discussing supervision of Resident #129 with Staff R, Receptionist. Staff B stated she was concerned about the evening shift (3 PM-11 PM) because the Receptionist (Staff R) leaves at 4 PM. Staff B stated she last saw Resident #129 on 04/16/22 at 3 PM sitting on his bed. Staff B stated she took a break and when she returned at 4 PM, she did not see Resident #129. Staff B stated she expected Staff C to provide supervision while also attending to other duties. Staff B said, I should have just put him on the 1 to 1 supervision. Staff B said, I didn't expect the CNA not to supervise the resident. I should have never trusted the CNA. I should have made sure he was supervised. I know better. It could have been worse. I did not do the right thing. I take full responsibility. As the charge nurse I should have followed the DON's orders. I didn't expect him to jump the fence. Staff B repeatedly said, I take full responsibility. Staff B stated she did not check if the electronic monitoring device was functioning. Staff B stated she had not received elopement in-services at this facility. Staff B stated she was aware of the elopement protocol from experience. Staff B stated she grabbed the elopement book when she realized she could not locate Resident #129, but found that he was not in the book. Staff B stated she called the elopement code and had CNAs start looking for the resident. Staff B stated she called the DON and the police. Staff B stated that the supervision expectation for a wandering resident was to keep an eye on the resident. Staff B stated that she had been notified that Resident #129 was at risk for wandering by the previous shift. Staff B stated that when the DON came in to do the search, they questioned me and had me do a written statement. The facility's corporate representatives called me yesterday (4/19/22) to find out what I put in place when I found out he was a wanderer. Outside of this, there has been no follow-up after the incident. A review of the facility's written statements pertaining to the investigation of Resident #129's elopement on 04/16/22 revealed no written statement by Staff B. The only information provided by the facility relating to Staff B was an undated employee interview statement completed by the Regional Nurse. The statement indicated Staff B last saw Resident #129 at 3 PM on 04/16/22 in his room. The statement noted employee stated she went outside on break when she came in she asked C.N.A. where he [Resident #129] was and started elopement procedure looking for him. The statement indicated Resident #33 witnessed Resident #129 climbing the fence. The statement said Staff B didn't see the resident as a risk and was in the locked courtyard. The resident was not agitated, was easily redirected and the wander guard was on. (continued on next page)

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	105394	A. Building B. Wing	04/22/2022

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/20/22 at 4:43 PM and 5:15 PM, a telephone interview was conducted with the DON. The DON stated she was notified that Resident #129 was exit seeking while she was in the building on Saturday, 04/16/22 around 12:30 PM. The DON stated she had observed Resident #129 in the hallway. The DON stated Staff B, LPN had reported that Resident #129 had an electronic monitoring device on him, but she did not see it. The DON stated she reviewed her phone record and confirmed she spoke to the nurse on duty, Staff B (Agency LPN) on 04/16/22 at 1:16 PM, and she had texted Staff L, Staffing Coordinator at 2:33 PM. The DON stated she asked Staff L, Staffing Coordinator, to place Resident #129 on 1 to 1 with Staff C, CNA. The DON stated Staff B asked Staff C to go inside and pass water to residents instead of providing the 1 to 1 supervision. The DON stated that Staff C left her area of assignment. The DON stated that they have documentation for the 1 to 1 provided on Saturday. (Documentation was requested from facility staff but not provided). The DON stated physician orders were required before an electronic monitoring device was applied. The DON stated whoever puts the device on should have called the doctor to receive the order. The DON stated the nurse should notify the physician of exit seeking behaviors and obtain orders. The DON said, I don't believe the physician was notified. The DON stated on Saturday afternoon (04/16/22) she received a call at approximately 4 PM and was told Resident #129 was nowhere to be found. The DON stated she instructed Staff B to call the police and she responded to the facility immediately and assisted with the search. The DON stated 5 police officers responded to the facility, and they brought in a helicopter to assist with the search. The DON stated that Resident #33 witnessed the elopement in the courtyard and had pointed to the fence. The DON stated that this resident was aphasic and does not speak clearly. The DON stated that it was on 04/16/22 around 4:30 PM when the resident provided this information. The DON stated she called emergency room s in the area in an attempt to locate the resident. The DON stated she called the Assistant Director of Maintenance (ADOM) to come to the building on 04/16/22 to check all the doors to make sure they were functioning. The DON stated that the ADOM said the gate in the back of the gazebo/courtyard area was not locked. The DON said, [The ADOM] yanked on the gate, and it opened. He said it has been like that for months. I was not aware of that. The DON stated the gate had a keypad which she thought was functional. The DON stated she was made aware the gate was not secured at the time the resident eloped. The DON stated she put a staff member in the courtyard to monitor the gate 24 hours a day until a vendor could come in to repair the keypad. The DON stated she was notified Resident #129 was found around 7 PM around [NAME] Blvd and Alternate US-19 and was transferred to the hospital. The DON stated after the incident on 04/16/22 she initiated the investigation, got staff statements and started education. The DON stated the education consisted of reviewing who was at risk, reviewing orders and care plans and filing an immediate federal report. The DON stated that she called the State Agency hotline to report the incident and they did not accept it. The DON stated that on the day of the elopement (4/16/22) she provided the facility with her 30 day notice of resignation. The DON stated, I was too overwhelmed. The DON stated she was at the facility on Monday, 4/18/22 but did not get to fully investigate the incident because the survey started. The DON indicated that she decided to leave the facility before the 30 days and no longer was employed by the facility. (On 04/19/22 at 10:21 AM the Nursing Home Administrator [NHA] informed the survey team that the DON walked out and the ADON would take over as DON until the arrival of the Corporate Chief Nursing Officer who would then fill the role of DON temporarily). (continued on next page)

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	105394	A. Building B. Wing	04/22/2022

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An attempt to interview Resident #33, who was said to have observed Resident #129's elopement by going over the courtyard exit gate was conducted immediately following the interview with the DON. The resident could not answer simple questions with words, vocalizations, writing or gestures. The resident was unable to provide any information related to the elopement. On 04/21/22 at 10:42 AM, Staff R, Receptionist stated she remembered Resident #129 because he was roaming the front of the building on Saturday, 04/16/22. Staff R said, He kept coming by the lobby. Staff R stated the door was locked and she thought Resident #129 had an electronic monitoring device, but she did not see the device. Staff R stated on 04/16/22 around 8:15 AM, Resident #129 had come to the lobby, carrying a bag. Staff R stated she did not speak to the resident, but she observed other staff speaking to him. Staff R stated she kept hearing Resident #129 saying he wanted to leave. Staff R stated that Resident #129 said this to a couple different staff members (Staff A and Staff F). Staff R stated she observed Resident #129 attempting to leave between 8:15 AM to 8:45 AM and between 1 PM and 1:30PM. Staff R stated she saw Resident #129 wander from the front lobby through the dining room and out to the courtyard/gazebo area several times. Staff R could not remember if there was staff present in the courtyard. Staff R said she checked on Resident #129 every so often until 2 PM. When asked if she was providing 1 to 1 supervision, Staff R indicated she was not told to provide 1 to 1 and doesn't even know what that means. She said, I don't know how they monitor. I did not see any staff following him around. Staff R confirmed that Resident #129 was not in the elopement book. Staff R stated around 4 PM just before her shift ended, the nurse (Staff B) had asked her to make an overhead page for Resident #129 through the facility's intercom system. Staff R stated after about 10 minutes she heard a second overhead page through the intercom system and realized Resident #129 had not been located. Staff R stated staff then initiated the search. An interview was conducted on 04/20/22 at 12:10 PM with Staff L, Staffing Coordinator. Staff L stated she was not in the building on Saturday, 04/16/22 but received a message from the DON about a resident needing 1 to 1 supervision around 12:45 PM on 01/16/22. Staff L stated she spoke to Staff A, C.N.A. and instructed him to have Staff C, C.N.A. provide the 1 to 1. Staff L stated she did not speak to Resident #129's assigned nurse (Staff B) about the 1 to 1. Staff L stated she received elopement training on Monday, 04/18/22. An interview was conducted with Staff F, CNA on 04/20/22 at 9:27 AM. Staff F stated he saw Resident #129 on Saturday, 04/16/22 around 11 AM - 11:30 AM. Staff F said, I thought he was a family member, and I was stopped by another staff from letting him out. He walked up to the front. He had a bag, like a plastic bag, like a family member would have. Staff F stated after that, he saw the resident a couple of hours later in the courtyard/gazebo area with no staff supervision. Staff F stated the last time he saw Resident #129 was between 1PM and 1:30 PM heading to the front lobby area. Staff F stated the Receptionist was at the door and Staff F along with another staff member, redirected Resident #129 to his room. Staff F stated that he assisted in the search for Resident #129 on 04/16/22 by looking around the doctor's offices across from the facility, but he did not locate the resident. (continued on next page)

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	105394	A. Building B. Wing	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 04/21/22 at 11:25 AM with Staff V, an Agency RN. Staff V stated that she admitted Resident #129 around 1:45 PM on Friday, 04/15/22. Staff V stated she did not get a report on Resident #129 prior to his arrival. Staff V stated she reviewed the paperwork the resident arrived with, completed the admission assessments and physician orders. Staff V stated Resident #129 started wandering instantly. Staff V stated Resident #129 wanted to smoke and kept walking out of the room. Staff V stated she did not have an assessment of Resident #129's mental status but figured we needed to keep him from exiting the facility. Staff V stated Staff N, LPN/Unit Manager told her to put an electronic monitoring device on Resident #129. Staff V stated she put the device on Resident #129 on 04/15/22 because he wanted to go out. Staff V said, I kept chasing him around. Staff V stated she did not know the facility policy on wandering residents or electronic device application. Staff V said, I figured the Unit Manager had the orders in place. On 04/21/22 at 11:35 AM, Staff N, LPN/Unit Manager confirmed she had worked on Friday 4/15/22 when Resident #129 was admitted . Staff N stated it was sometime early in the afternoon. Staff N stated she was covering both units that day and did not have any interaction with Resident #129. Staff N could not recall if she was notified the resident was an elopement risk. Staff N said, I might have. I was focused on another resident. Staff N said if a resident was displaying elopement behaviors, the expectation was to call the ph [TRUNCATED]

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	105394	A. Building B. Wing	04/22/2022

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37999 Based on observations, record reviews, and interviews, the facility failed to ensure controlled substances for Resident #61, #72, #45, #40, and # 277 were reconciled at the time of administration in one (300-hall) of four medication carts. Findings included: On 4/19/22 at 5: 30 p.m., an observation of the 300-hall medication cart was conducted with Staff U, Licensed Practical Nurse (LPN). The observation identified the Medication Monitoring/Control Records for five residents were not accurately reconciled at the time of administration. Staff U stated, on 4/19/22 at 5:18 p.m., she signed out the controlled substances after she dispensed the medication, because if the resident refused the medication she would have to waste it and have another nurse witness the wasting. During the review of the controlled substances on 4/19/22 at 5:30 p.m., the staff member confirmed the number of tablets/capsules on the blister cards of the controlled substances were inaccurate, as she had previously administered the medications as follows: - Resident #61: Adderall 20 milligram (mg) - record indicated 11, actual count of tablets 10. The Medication Administration Record (MAR) for the resident identified the resident received a dose of Adderall as scheduled at 5:00 p.m. on 4/19/22 which was not accounted for on the Control Record. - Resident #72: Tramadol 50 mg - record indicated 16, actual count of tablets 15. The MAR for Resident #72 indicated the resident had been administered a dose of Tramadol as scheduled at 5:00 p.m. on 4/19/22 which was not accounted for on the Control Record. - Resident #45: Hydrocodone/APAP 5/325 mg - record identified 12 tablets, tablet count 11. The MAR for Resident #45 indicated the resident had been administered a dose of Norco on 4/19/22 at 8:02 a.m. and 9:15 p.m. The dose Staff U had identified as given on 4/19 was not accounted for. - Resident #40: Percocet 10/325 mg - record identified 16, tablet count 15. The MAR did not indicate the resident had been administered a dose prior to observation on 4/19/22. - Resident #277: Alprazolam 2 mg - record identified 8, tablet count 7. Resident #277's MAR identified the resident had been administered the scheduled dose of Alprazolam (Xanax) at 5 p.m. on 4/19/22 that was not accounted for on the Control Record. On 4/19/22 at 5:49 p.m., the Interim Director of Nursing (DON) stated narcotics were to be signed out at the time they were given. On 4/20/22 at 8:45 a.m., the Interim DON stated she had spoken with Staff U and the nurse had confirmed the findings. An interview at 2:13 p.m. on 4/18/22 was conducted with Resident #40. The resident stated he was aware of a recent delay in the refilling of his pain medication. (continued on next page)

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	105394	A. Building B. Wing	04/22/2022

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 4/21/22 at 3:34 p.m., the Interim DON reported an investigation conducted by the previous DON was completed related to the controlled substances of Resident #40. The Interim stated the nurse on Sunday went to administer the resident's oxycodone and there was none on the cart. The nurse called the pharmacy for a refill and was informed it was too soon to refill. The Interim stated the investigation revealed 4 cards of 30 tablets had been delivered and one narcotic reconciliation sheet was missing. The investigation revealed statements from nurses reported nothing unusual and the count for the narcotic was correct. The Interim reported all nurses were educated and the education was added to the agency staff orientation. Staff U reported during the investigation on 3/28/22 she had noticed Staff J (LPN) was not signing out the narcotics. The facilities Job Description for a Charge Nurse (LPN or RN) identified the essential duties and responsibilities for the nurse was to Verify that narcotic records are accurate for your shift and Notify the Nurse Supervisor of all drug and narcotic discrepancies noted on your shift. The policy - Medication Storage, implemented 11/2020, and reviewed 3/15/2022, identified any discrepancies of narcotics and controlled substances which cannot be resolved must be reported immediately as follows: - i. Notify the DON, charge nurse, or designee and the pharmacy. The policy - Medication Administration, undated, indicated Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection, The policy guideline included the following: - 15. Observed resident consumption of medication. - 16. Wash hands using facility protocol and product. - 17. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR. - 18. If medication is a controlled substance, sign narcotic book.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105394	A. Building B. Wing	04/22/2022

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37999 Based on observation, record review, and interview, the facility failed to ensure the accuracy of medical records for 1 (#30) of 36 sampled residents as evidenced by a report by a staff member that tracheostomy care was not completed but documentation indicated it was. Findings included: Review of Resident #30's Admission Record revealed diagnoses to include: attention to tracheostomy, not elsewhere classified anoxic brain damage, and persistent vegetative state. A review of Resident #30's active physician orders revealed an order dated 4/11/22 to change trach ties daily and as needed (PRN) if soiled every day shift. On 4/20/22 at 10:11 a.m., a request was made to observe trach care for Resident #30 by the assigned Licensed Practical Nurse (LPN), Staff M. Upon request, Staff M stated, this is too much, just too much. On 4/20/22 at 4:50 p.m., Staff N, Unit Manager (UM)/LPN, stated that Staff M informed her that Resident #30's tracheostomy care was not completed. The UM confirmed she was aware of the surveyor's request to observe trach care and that she would make sure the 3 p.m. - 11 p.m. shift nurse changed the trach ties. Observation conducted during the interview of Resident #30 revealed it could not be determined if the ties were changed. A review of Resident #30's April 2022 Treatment Administration Record (TAR) revealed Staff M had documented that the trach ties had been changed at 2:36 p.m. on 4/20/22. On 4/20/22 at 5:20 p.m., Staff U, Licensed Practical Nurse (LPN), confirmed that Staff M documented that the trach ties had been changed, and she would not usually change them until 8 p.m. Review of the Job Description for Charge Nurse (LPN or Registered Nurse [RN]) identified it was the duty and responsibility of the nurse to: - Perform routine charting duties as required in accordance with established charting and documentation policies and procedures. Review of the policy titled Documentation in Medical Record with a copyright date of 2022 revealed: Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation . 3. Principles of documentation include, but are not limited to: a. Documentation shall be factual, objective, and resident centered. (continued on next page)

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. False information shall not be documented . b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care .