STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105465	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Arbor Springs	1501 SE 24th Rd Ocala, FL 34471

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523 Based on observation, interview, and record review, the facility failed to ensure residents received the correct oxygen flow rate for 1 of 3 residents, Resident #6, reviewed for respiratory services. Findings include: During an observation on 3/6/2025 at 9:18 AM Resident #6 was lying in bed with oxygen being administered at 2 liters per minute via tracheotomy mask. During an observation on 3/6/2025 at 12:54 PM with the Director of Nursing (DON), Resident #6 was lying in bed. Oxygen was being administered at 2 liters via tracheostomy mask. Review of Resident #6 physician order dated 2/19/2025 read, Trach Ventilator Setting: FI027 [fraction of inspired oxygen], 5Lo2 (5 liters oxygen) humidified. Review of Resident #6 Admission Record documented the resident was admitted on [DATE] with diagnosis that includes but not limited to chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and sleep apnea. During an interview on 3/6/2025 at 12:56 PM the DON stated, Resident #6 has orders for 5 liters he was at 2 liters. Staff should review orders and verify that the resident flow rate is correct. Staff should follow physician orders. Review of the policy and procedure titled Oxygen Therapy with a revision date of 8/28/2017 read, Procedure: Review physician's order. Start O2 (oxygen) flowrate at the prescribed liter flow or appropriate flow for administration device.

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