

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Aspire at Rosewood		STREET ADDRESS, CITY, STATE, ZIP CODE 3920 Rosewood Way Orlando, FL 32808	

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)
<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51023</p> <p>Based on interviews and record review, the facility failed to provide the resident and his responsible party access to his personal and medical records following a written request for 1 of 1 residents reviewed for medical grievances, of a total of 6 residents, (#2).</p> <p>Findings:</p> <p>Resident #2 was admitted to the facility on [DATE], with a diagnosis of seizures, type 2 diabetes, protein-calorie malnutrition, hypertension, alcohol dependence, anxiety, and history of a brain abscess.</p> <p>The Admission Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 12/15, which indicated the resident was cognitively intact.</p> <p>Review of the resident's electronic medical record revealed a document titled Healthcare Power of Attorney which was scanned into the resident's chart on 3/23/24. Under the section Designation of health care agent, the document listed the resident's brother to serve as his health care agent. Under the section titled Medical information and Medical records it indicated, acting on my behalf, my health care agent may have access to all of my medical information and photocopies of my medical record from my health care providers. This document was signed and notarized on 3/05/18.</p> <p>Review of the resident's electronic medical record revealed a document titled Authorization for Release of Protected health Information which was scanned into the resident's chart on 3/23/24. Under the section Appointment of Authorized Recipients, it stated the resident appoints the following persons as authorized recipients for health care disclosure under the Standards for Privacy of Individually Identifiable Health Care Information under the Health Insurance Portability and Accountability Act of 1996. Individuals listed included resident #2's brother.</p> <p>(continued on next page)</p>

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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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's clinical record revealed the facility form Consent for Obtaining Medical Information. On the form it indicated the resident authorized the facility to release copies of the medical record to the resident's brother. The resident's brother checked the box that indicated he was requesting a complete copy of the medical record. Written underneath this section was a note that read, email to: [residents #2's email address]. Records to be emailed daily. This document was signed on 5/27/24. At the bottom of the document, resident #2's brother signed the form as the person authorized to act on the resident's behalf and written next to documentation required was the phrase on file.</p> <p>Interview with the Medical Records staff on 7/01/24 at 1:23 PM, revealed that typically it was her responsibility to handle the requests for medical records. She explained she had only been employed in the position for 2 weeks, so she did not handle resident #2's medical records request on 5/27/24. She stated the process was for medical records to send the filled-out Consent form to the corporate legal department for them to review before the release of information.</p> <p>Follow up interview with Medical Records staff later that day at 2:33 PM, revealed the receptionist handled the task of sending the filled-out consent forms to the corporate legal department while the facility was in between medical record personnel.</p> <p>On 7/01/24 at 2:37 PM, the Administrator revealed the facility just realized that day, the legal department did not receive the forms as they had been sent to the wrong email address. He stated they were going to send them to the correct email address and reach out to those who requested the medical records about the mix up.</p> <p>On 7/01/24 at 2:40 PM, the receptionist confirmed she was responsible for sending the medical records consent to the legal department while the facility was in between medical record personnel. She also stated she typically did not receive an email response from the legal department, nor did she receive a response from the wrong email address that informed her she sent the information to the incorrect email recipient.</p> <p>Review of the facility policy and procedure for Request for Medical Records/ Release of Information revised on 7/05/23 revealed that requests made by current residents to view their record will be granted within 24 hours of the request. In some instances, the legal department may be consulted. If the consent form was sent to the Legal Department for review, and the medical records custodian does not receive a response from the Legal Department with authority to release or not release the records within 72 business hours of the request, the medical record custodian will send the request a second time and follow up with a phone call.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646</p> <p>Based on interview and record review, the facility failed to revise a fall care plan to reflect fall interventions for 1 of 3 residents reviewed for care plans, of a total sample of 6 residents, (#1).</p> <p>Findings:</p> <p>Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including multiple fractures of pelvis, fracture of left patella, dislocation of right hip, displaced fracture of lateral malleolus of left fibula and unsteadiness on feet.</p> <p>Review of resident #1's medical record revealed a Change in Condition evaluation completed dated 3/03/24 which indicated resident #1 slipped out of his wheelchair and was observed sitting on the footrest. Staff assisted resident back into his wheelchair. The form did not list any new interventions to be implemented. The medical record also contained a Change in Condition evaluation dated 3/24/24 which indicated resident #1 was observed as he slid from the seat of his wheelchair onto the footrests. The form also did not list any new interventions to be implemented.</p> <p>A fall care plan initiated 1/22/24 and revised 3/25/24 indicated resident #1 had an actual fall without injury on 9/11/23 and 3/24/24. The care plan did not identify the fall on 3/03/24 and did not indicate any new interventions related to the fall on 3/03/24.</p> <p>On 7/02/24 at 1:32 PM, the Administrator and Regional Nurse Consultant (RNC) reviewed the incident reports for resident #1's falls on 3/03/24 and 3/24/24. The NHA confirmed the falls were identical as to resident #1 sliding from his chair onto the footrests. The Administrator and RNC reviewed the medical record and verified that no new interventions were added to resident #1's care plan, task list or nurse aide Kardex. The Administrator acknowledged if an intervention had been added, the likelihood of the same incident occurring would be reduced.</p> <p>Review of the facility's Plans of Care policy and procedure indicated the interdisciplinary team would review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646</p> <p>Based on interview and record review, the facility failed to ensure appropriate fall interventions were in place to prevent further falls for 1 of 3 residents reviewed for falls, of a total sample of 6 residents, (#1).</p> <p>Findings:</p> <p>Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including multiple fractures of pelvis, fracture of left patella, dislocation of right hip, displaced fracture of lateral malleolus of left fibula and unsteadiness on feet.</p> <p>Review of the Minimum Data Set quarterly assessment with assessment reference date 2/25/24 revealed resident #1 had long-term and short-term memory problems and severely impaired cognitive skills for daily decision making. He was dependent on staff for activities of daily living and used a wheelchair for mobility.</p> <p>Review of the facility's incident log revealed resident #1 fell on [DATE], 3/03/24 and 3/24/24.</p> <p>Review of the medical record revealed a Change in Condition evaluation completed by Licensed Practical Nurse (LPN) A dated 3/03/24 which indicated resident #1 slipped out of his wheelchair and was observed sitting on the footrest. He was assisted back into the wheelchair. The form did not list any new interventions to be implemented. The medical record also contained a Change in Condition evaluation completed by LPN B dated 3/24/24 which indicated resident #1 was observed sliding from the seat to the footrests of his wheelchair. The form did not list any new interventions to be implemented.</p> <p>A fall care plan initiated 1/22/24 and revised 3/25/24 indicated resident #1 had an actual fall without injury on 9/11/23 and 3/24/24. The care plan included interventions to initiate neuro checks for 72 hours (1/22/24) and move resident closer to the nursing station (1/23/24). No interventions were added for the fall which occurred on 3/03/24.</p> <p>On 7/01/24 at 3:40 PM, LPN A stated she was passing meds on 3/03/24 when she observed resident #1 seated on the footrests of his wheelchair. She explained she called for help and she and another staff member assisted resident #1 back into his chair. LPN A could not remember who the other staff member was but recalled resident #1 did have a cushion in his chair which slid down with him. She explained a staff member replaced the seat cushion before they placed him back in the chair.</p> <p>On 7/02/24 at 1:32 PM, the Administrator and Regional Nurse Consultant (RNC) reviewed the incident reports for resident #1's falls on 3/03/24 and 3/24/24. The Administrator confirmed the falls were identical as to resident #1 sliding from his chair onto the footrests. The Administrator and RNC reviewed the care plan and verified that no new interventions were added nor were they added to the task list or Kardex for nursing staff to implement. The Administrator explained if an intervention had been added, the likelihood of the same incident occurring would be reduced. He acknowledged the facility failed to help prevent the incident by not putting an appropriate intervention in place.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Fall Management policy and procedure indicated the purpose was to identify residents at risk for falls and establish or modify interventions to decrease the risk of a future fall(s) and minimize the potential for a resulting injury. The document clarified that the care plan and nurse aide Kardex would be updated with interventions.</p>		