STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105480	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Rosewood	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)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 51234 Based on observation, interview, and record review, the facility failed to follow podiatry treatment plan and ensure a timely follow-up appointment with a podiatrist for 1 of 1 residents reviewed for podiatry, of a total sample of 4 residents, (#1). Findings: Review of resident #1's medical record revealed diagnoses of type 2 diabetes mellitus, peripheral vascular disease, hemiplegia (severe loss of strength) and hemiparesis (weakness) following stroke affecting left non-dominant side. The American Diabetes Association's in the section titled, Foot Complications described, People with diabetes can develop many different foot problems. Even ordinary problems can get worse and lead to serious complications (retrieved from www.diabetes.org on 10/02/24). Review of resident #1's medical record revealed a podiatry visit report with a date of service of 8/22/24. The report detailed on physical exam the podiatrist noted resident #1 was unable to differentiate sharp/dull sensations in both feet. Resident #1 had three nonpalpable (could not be felt by hand) and one diminished pulse, regarding four pulse points, in her foot and ankle area indicating her blood circulation was diminished to these areas. Resident #1's diagnoses on this evaluation were: type 2 diabetes with other diabetic neurological complication, ingrowing nail, tinea unguium (toenail fungus), and nail dystrophy (abnormal changes in shape, color, texture and growth of nails). In the section of the note titled Follow-up indicated a partial nail avulsion (removal) was performed on the medial nail plate of the left great toe. Wound care orders were to apply a topical antibiotic ointment and band-aid to the left great toe for 10 days. The report listed a follow-up visit for podiatry in 2-3 months, or sooner should any concerns or problems arise. Review of resident #1's Treatment Administration Record (TAR) revealed that from 8/22/24 through 10/02/24 nursing staff had signed they had cleansed resident #1's left great toe with normal saline, applied Bactroban (a topical antibiotic) ointment, covered with dry gauze, and secured with tape daily. This treatment was 32 days longer than the podiatrist had recommended on 8/22/24. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/03/24 at 1:40 PM, the Director of Nursing (DON) reviewed resident #1's podiatry wound care report dated 8/22/24 for the left great toe and compared it to the TAR wound care orders for the left great toe which continued until 10/02/24. She could not explain why treatment was done longer than the 10 days recommended by the podiatrist, and confirmed the order on the TAR should have been discontinued. On 10/04/2024 at 10:56 AM, the DON stated resident #1's assigned nurse had asked her to have the Attending Physician examine resident #1's left great toe on 9/16/24 due to some redness. The DON confirmed she had not called the podiatrist about the left great toe concern made by the assigned nurse. The DON verified the attending physician ordered a podiatry referral on 9/16/24., but no podiatry visit had been scheduled for resident #1 since the referral was made. The DON said that Social Service staff should schedule the referral visit, and the podiatrist would come to the facility to provide care to the patient. On 10/03/24 at 3:29 PM, the Social Service Director confirmed the podiatry referral made on 9/16/24 for resident #1 had not been scheduled yet. He stated resident #1 was not scheduled to have an appointment until the next regular time the podiatrist was scheduled to visit the facility and that date had not yet been set. On 10/3/24 at 3:30 PM, in a telephone interview, the receptionist at the facility's contracted podiatrist office stated the podiatrist was not yet scheduled to have a service date at the facility. He confirmed no other facility visits were on their current schedule. On 10/04/24 at 10:20 AM, the Advanced Practice Registered Nurse (APRN) explained she examined resident #1's toes today at the request of the DON. She confirmed some redness on the left great toe where the toenail was no longer present. She explained the redness could relate to, remnants of an infection. The APRN said she was going to order an antibiotic medication for the possible infection and added that resident #1's toenails were elongated and should be clipped.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51234 Based on interview and record review, the facility failed to ensure a resident who was continent of bladder and bowel received services such as scheduled toileting or prompted voiding, and the needed assistance to maintain their continence, for 1 of 3 residents reviewed for bowel and bladder/incontinence care, of a total sample of 4 residents, (#1). Findings: Resdient #1 was admitted to the facility on [DATE] with diagnoses that included stroke, type 2 diabetes mellitus, and partial weakness and paralysis of the left non-dominant side after stroke. Review of resident #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #1 was cognitively intact with no behavioral symptoms or rejection of care necessary to achieve the resident's goals for health and well-being. Section H of the assessment indicated she was always incontinent of bowel and bladder and that a toileting program (e.g. scheduled toileting, prompted voiding, or bladder training) had not been attempted upon admission or reentry. On resident #1's Quarterly MDS assessment dated [DATE] the same responses for Section H were present, as the previous assessment on 6/27/24. Toileting tailored to the resident's needs rather than using an absorbent brief has the potential of: increasing dignity, satisfaction, and support for the holistic needs of the resident when they achieve their highest level of continence, has the potential to reduce risk of skin breakdown and moisture-associated skin damage (MASD), and lowered risk of infection, (retrieved on 10/09/24 from www.medline.com.) On 10/03/24 at 10:20 AM, the MDS Coordinator stated she did not know if resident #1 had the sensation/urge to void, urinate or have a bowel movement. She said she had never heard resident #1 say if she had to urinate nor have a bowel movement. The MDS Coordinator confirmed she had heard resident #1 say after she had voided that she had urinated and/or had a bowel movement, but she was not sure if the facility even had a mechanical lift or mechanical lift toileting sling to assist resident #1 to the bathroom. On 10/03/24 at 12:40 PM, resident #1 explained she had the sensation/felt the urge to urinate or have a bowel movement before it happened. She stated she usually went in her adult brief, but she would use the toilet instead if it was offered. On 10/03/24 at 10:00 AM, the Director of Rehabilitation stated resident #1 needed maximum assistance for toileting and required use of a mechanical lift to transfer between her wheelchair and bed. She acknowledged there was nothing to prevent staff from utilizing a mechanical lift to transfer resident #1 to the bathroom/toilet. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/03/24 at 1:40 PM, the Director of Nursing (DON) explained the facility did not have any mechanical lifts designed to transfer residents to a toilet nor any slings to be used with the mechanical lifts designed to place a resident on a toilet. She said resident #1 had not told the facility she needed to be toileted and that resident #1 usually told staff after she had already voided. The DON said she was unaware if resident #1 had the sensation/urge to know she needed to void before she would go. She acknowledged she did not have any documentation of a toileting program trial or the offering of a bed pan for resident #1 since her admission. On 10/03/24 at 1:45 PM, the DON and Regional Nurse interviewed resident #1 with the surveyor present. Resident #1 stated she knew when she had to void, by both bladder and bowel. Resident #1 agreed she would be willing to use a toilet if it was offered.