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	11/25/2024

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview, and record review, the facility failed to ensure admission physician orders for immediate care of surgical sites were obtained for 1 of 2 residents reviewed of a total sample of 7 residents, (#2). Findings Resident #2, a [AGE] year-old female was admitted to the facility on [DATE], and readmitted on [DATE]. Her diagnoses included fracture of upper and lower end of the right fibula, fracture lower end of the right tibia, and physeal fracture of the lower end of the right fibula. Review of the resident's Medical Certificate for Medicaid Long-Term Care Services And Patient Transfer Form (3008) dated 11/23/24 revealed the resident's primary diagnosis was right ankle fracture, and documentation noted the resident had sutures to her left lower extremity, and an ace bandage wrap to her right lower extremity. The hospital's Brief op (operative) note dated 11/19/24 revealed an operative fixation of the right ankle and removal of external fixator was performed on resident #2. The Orthopedic Trauma Surgery Discharge Instructions printed on 11/23/24 read, Wound Care/Dressings: Aquacel dressings should stay on for 5 days after surgery . After Aquacel is removed, perform daily (and as needed) dressing changes with gauze and tape (or ACE wrap) .Do not place any ointments, lotions, or creams on your surgical incisions. Do not submerge surgical sites in water. Aquacel is a hydrofiber dressing that is used to treat wounds .has been shown to be effective in .surgical wounds. (retrieved on 12/05/24 from pubmed.ncbi.nlm.nih.gov). A review of resident #2's Admission/Readmission Data Collection document dated 11/23/24, revealed the resident had a surgical wound on her left lateral knee with 11 stitches, the lower leg had two stitches, and there was a cast on her right lower leg. Clinical record review of the resident's active and discontinued physician orders revealed no orders for the surgical sites, until 11/25/24. On that date, the physician orders were, monitor surgical wound for s/s (signs/symptoms) of infection, cleanse surgical wound on left lower leg with normal saline, pat dry and cover with dry dressing every day shift, cleanse surgical wound on left lateral knee with normal saline, pat dry and cover with dry dressing every day shift. (continued on next page)

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

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/24 at 1:30 PM, Licensed Practical Nurse (LPN) B, acknowledged she was resident #2's primary nurse. LPN B stated the resident was readmitted to the facility on [DATE] and had a surgical wound with staples. She stated the resident would be seen by the wound care physician and continued with the hospital discharge orders for wound care. LPN B stated she had not completed the resident's dressing as yet. On 11/25/24 at 2:08 PM, resident #2 was sitting up in bed watching television. The resident uncovered her left leg to show staples from her knee down with no dressing present. The area/staples were open to air, and her right leg was wrapped with bandage wrap. On 11/25/24 at 4:22 PM, the Regional Nurse reviewed the resident's physician orders. She acknowledged the resident was readmitted to the facility on [DATE], and no orders were identified to address the surgical site (s) until 11/25/24. On 11/25/24 at 4:38 PM, the Director of Nursing (DON) explained when a resident was admitted to the facility, the admission nurse reviewed the resident's hospital's discharged orders, and would enter the orders into the facility's electronic medical record (EMR) for the individual resident. She stated that normally residents came to the facility with physician orders for wound care, and if there were no orders, the nurse needed to notify the physician and obtain orders. Resident #2's clinical records were reviewed with the DON. She acknowledged the resident was readmitted to the facility on [DATE], and orders for surgical site(s) care was not obtained and entered into the EMR until 11/25/24. She said the expectation was that admission physician orders should have been in place, and hospital's orders for the surgical site should have been transcribed to the resident's EMR. The facility's policy Physician Orders with effective date of 11/30/2014, and revision date of 3/03/2021 read, The center will ensure that Physician orders are appropriately and timely documented in the medical records. Admission Orders: Information received from the referring facility or agency be reviewed, verified with the physician and transcribed to the electronic medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51023 Based on observation, interview and record review, the facility failed to develop a comprehensive individualized care plan for 1 of 3 residents of a total 7 residents, (#5) Findings: Resident #5 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis, major depressive disorder, anxiety, history of falls, and hypertension. On 10/3/24 she was re-hospitalized on chest pain and then returned to the facility on [DATE]. Review of resident's care plan on 11/25/24 revealed a care plan with only one focus which was initiated on 10/24/24. The focus noted the resident had nutritional problem or potential nutritional problem related to hypertension, anemia, major depressive, hemiplegia, hypotension, morbid obesity, venous thrombosis, iron deficiency anemia, anxiety disorder, muscle weakness, and Mini Nutritional Assessment score reflects risk for malnutrition. Review of a care plan initiated on 6/26/24 revealed the care plan had been cancelled following resident's transfer to the hospital. The care plan initiated on 6/26/24 included risk for falls related to deconditioning, use of antidepressant medications related to depression, use of anticoagulation therapy related to history of deep vein thrombosis and risk for acute pain related to impaired mobility. Review of resident #5's Minimum Data Set (MDS) history revealed a MDS Discharge Return Not Anticipated initiated on 10/3/24 which was followed by a MDS Discharge Return Anticipated on 10/3/24. Interview with the MDS coordinator at 11:45 am on 11/25/24 revealed the previous MDS coordinator initially noted the resident as discharge not anticipated which canceled the care plan. The resident was supposed to be listed as discharge return anticipated. The MDS coordinator agreed the resident went without an accurate care plan from 10/21/24 till 11/25/24. Review of the facility's Plan of Care policy and procedure revised on 9/25/17 revealed that an individualized person centered plan of care may include resident's strengths, services to attain residents highest practicable physical, mental and psychosocial well-being as required by state and federal regulatory requirements.'

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview, and record review, the facility failed to follow physician orders for surgical pin site dressing for 1 of 2 residents reviewed for surgical wounds, of a total sample of 7 residents, (#1). Findings: Resident #1, a 49- year-old female was admitted to the facility on [DATE]. Her diagnoses included anterior dislocation of proximal end of tibia, right knee, generalized weakness, pain in right knee, diabetes type II, cardiac murmur, depression, and anxiety disorder. Review of the resident's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was intact with a Brief Interview For Mental Status (BIMS) score of 15 out of 15. The assessment noted the resident was dependent on staff assistance for activities of daily living, required substantial/maximal assistance of staff for chair/bed-to chair transfer, and had surgical wound(s). Review of the resident's clinical records revealed a physician order dated 3/05/34, to paint pin site with Betadine, pat dry, cover with dry gauze and secure with tape daily. This order was discontinued on 3/06/24. Review of the resident's Treatment Administration Record (TAR) revealed a blank space on 3/06/24, and there was no documentation to indicate the treatment was completed. Physician order on 3/07/24, noted to clean the pin site(s) with hydrogen peroxide and normal saline, pat dry, cover with dry gauze, and secure with tape every day shift. This order was discontinued on 4/11/24. Review of the resident's TAR revealed blank spaces on 3/08/24, 3/15/24, and 3/28/24. There was no signature or documentation to indicate the physician's orders were completed. On 3/09/24, and on 3/24/24, the code 2 was documented, indicating the resident refused, and on 3/12/24 the code 3 was documented, indicating a Leave Of Absence. Documentation to indicate the physician was notified of the resident's refusal on 3/09/24, and 3/24/24 was not identified. On 11/25/24 at 1:41 PM, the resident's clinical records were reviewed with the Assistant Director of Nursing/Unit Manager (ADON /UM). She acknowledged the blank spaces on the resident's TAR for the dates identified, and explained there should have been something documented, and the spaces should not be left blank. The ADON/UM said that if the resident refused the treatment, a code should be placed, and the TAR should be signed by the nurse. On 11/25/24 at 3:15 PM, the Director of Nursing (DON) stated that when treatment was provided the residents' TAR should be signed by the nurse. The resident's TAR was reviewed with the DON, she acknowledged that blank spaces were on the TAR for the dates identified, and that a progress note regarding the treatment could not be identified for the dates noted. As per the DON, the facility did not have a policy to address documentation on the residents' TAR. However, the facility's policy Administering Medications revised April 2019 read, Topical medications used in treatments are recorded on the resident's treatment record (TAR).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on observation, interview, and record review, the facility failed to ensure medications were administered per professional standards for 1 of 7 residents, (#3). Findings Resident #3, an 81- year-old female was admitted to the facility on [DATE], with her most recent readmission on 6/23/24. Her diagnoses included end stage renal disease, diabetes type II, hypertension, chronic pain, and major depressive disorder. On 11/25/24 at 9:57 AM, a medication cup with medications was observed on resident #3's tray table. The resident stated the medications were left there by the nurse, and she would be take the medication momentarily. The resident stated she had breakfast and the nurse bought the medications in, but she fell asleep before taking the medications. On 11/25/24 at 10:00 AM, observation of the cup with medications on the resident's tray table was conducted with Registered Nurse (RN) A the resident's assigned nurse. RN A acknowledged the cup with the medications was on the resident's tray table and confirmed she gave the resident her medications. Record review of the resident's Medication Administration Record (MAR) revealed the resident's medications were documented as given at 9:26 AM. This was acknowledged by RN A, who stated she was aware medications were not to be left at the resident's bedside. RN A verbalized she was called away from the resident for an emergency, but did not take the medications out with her, and forgot to go back and check on the resident. Review of the MAR revealed medications administered by RN A at 9:26 AM included Bumex 2 milligram (mg) for edema, [NAME]-Vita tablet for end stage renal disease, Sevelamar Carbonate 800 mg x 3 tablets, Ocular Vitamin for macular degeneration, Fish oil 500 mg for high triglyceride, and Cetirizine for sinus congestion. On 11/25/24 at 10:40 AM, the Director of Nursing (DON) stated medications should not be left at the resident's bedside, and nurses should ensure medications were taken by the resident before leaving. She stated that if the resident refused their medications, and wanted the nurse to come back, the nurse should take the medications with her. If responding to an emergency, the medications should be taken out with the nurse, and not left at the resident's bedside. On 11/25/24 at 3:24 PM, the Regional Nurse stated the expectation was that nurses should watch the resident take their medications, and medications should not be left at the resident's bedside. The policy Administering Medications revised April 2019 read, For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR may be flagged. After completing the medication pass, the nurse will return to the missed resident to administer the medication.