

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Aviata 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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to report allegations of abuse to the state Agency for Health Care Administration (AHCA) within the required timeframes for 2 of 5 residents reviewed for abuse, in a total sample of 15 residents, (#4 and #9). Findings: 1. Review of resident #4's medical record revealed she was admitted to the facility on [DATE] with diagnoses including gastritis, anxiety disorder, major depression disorder, and osteoarthritis. Review of the admission Minimum Data Set assessment with an Assessment Reference Date of 6/16/26 revealed resident #4 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. On 7/08/26 at 2:50 PM, resident #4 stated on 7/01/26 her assigned nurse, Registered Nurse (RN) B, administered her prescribed Miralax in a clear medication cup. She shared that while swallowing the medication, she felt something else in her mouth, spit it out, and discovered two tablets in the cup. Resident #4 indicated she asked RN B what had been given to her, and the nurse responded it was something to make her stronger. She stated following the medication incident, RN B became upset, attempted to grab her telephone while she was speaking with her daughter, and tried to intimidate her. Resident #4 stated she felt RN B had assaulted her and RN B asked her not to report the incident. Resident #4 stated she verbally informed facility staff about the incident the previous week and later prepared a written letter describing the events, which she provided to the Social Services Assistant on 7/07/26. Resident #4 provided a signed, six-page typed letter dated 7/02/26. The letter described after the medication incident, RN B yelled at resident #4 and other residents who were sitting together in the hallway, asking who was going to speak with the Director of Nursing (DON). The letter further documented RN B followed resident #4 to her room while she was speaking with her daughter by telephone, screamed at her, attempted to take the telephone from her, and continued confronting her after the resident asked the nurse to leave the room. The letter stated, She (RN B) replied, 'Oh, you can stand, but you don't have any balance,' and used her body to push me. I walked away from her and told her that was assault. On 7/08/26 at 3:51 PM, the Social Services Director (SSD) confirmed he received a copy of resident #4's written letter from the Social Services Assistant the previous day. The SSD stated the letter was entered into the facility's grievance log, and the Administrator (NHA) had been notified and was addressing the matter. The SSD indicated the NHA served as the facility's Abuse Coordinator. On 7/08/26 at 4:04 PM, the Social Services Assistant stated he received resident #4's written letter at approximately 4:00 to 5:00 PM on 7/07/26. He stated he read the letter, recognized it contained allegations of abuse, and immediately emailed a copy to the NHA, the SSD and the DON. The Social Services Assistant indicated the email was sent on 7/07/26 at 4:45 PM. He stated resident #4 told him on Monday 7/06/26 she wanted to discuss a concern but preferred to put in writing first. He indicated resident #4 did not disclose any allegation of abuse before providing the (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
--	-------	-----------

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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Aviata 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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	written letter. On 7/08/26 at 4:40 PM, during a joint interview between the NHA and the DON, the NHA stated she was responsible for the overall health and safety of the residents and served as the facility's Abuse Coordinator. She indicated staff received education regarding abuse, neglect, and mandatory reporting requirements and were instructed to notify her immediately of any allegation of abuse by telephone or text message. The NHA stated allegations involving abuse must be reported to the appropriate agencies within two hours after the facility becomes aware of the allegation, with the investigation completed within five business days. She further stated reportable allegations were also reported to the Department of Children and Families, law enforcement, the regional team, the Medical Director and the resident's representative. The NHA stated she became aware of resident #4's allegation after reviewing the email and attached letter sent by the Social Services Assistant. She stated the facility was in the process of submitting the required report to AHCA; however, she acknowledged the required reporting timeframe had not been met because more than two hours had elapsed since the facility became aware of the allegation. The NHA confirmed the email containing resident #4's written allegation had been sent the previous evening. She stated the situation presented differently and resident #4 had not previously alleged abuse. The NHA acknowledged she had not yet spoken with staff regarding the alleged abuse incident. On 7/08/26 at 10:24 PM, during a telephone interview, RN D stated RN B informed her the medication incident involving resident #4 had been reported to the appropriate individuals during shift report. RN D recalled resident #4 appeared nervous and frightened while discussing the incident and expressed RN B had been rude to her. RN D further stated resident #4 did not describe any physical contact, only that RN B had been rude. RN D stated she did not report the resident's concerns to anyone because she believed RN B had already reported the incident. On 7/09/26 at 11:23 AM, Certified Nursing Assistant (CNA) E stated resident #4 told her on 7/02/26 about an incident that had occurred the previous day. CNA E indicated resident #4 appeared upset and was shaking while describing the events. According to CNA E, resident #4 reported RN B administered Miralax containing two tablets, and when she felt the tablets in her mouth, she spit them out and questioned the nurse about the medication. CNA E stated resident #4 reported RN B initially walked away without answering, then later made a muscle gesture with her arm and stated the tablets were vitamins that would make her stronger. CNA E continued that resident #4 reported she argued with RN B while speaking with her daughter by telephone, RN B attempted to take the telephone from her and the resident told RN B not to touch her. CNA E stated resident #4 reported RN B then moved very close to her, making chest-to-chest contact, in an intimidating manner. CNA E stated the resident told her she felt she had been assaulted by RN B. CNA E stated she advised resident #4 to notify Social Service staff. CNA E stated later that day, resident #4 told her she had spoken with the Social Services Assistant. CNA E stated she did not speak with the Social Services Assistant to verify what the resident reported. CNA E acknowledged she understood allegations of abuse were required to be reported immediately and that any employee could report concerns directly to either the SSD or the NHA. She stated each employee was responsible for reporting allegations of abuse and the facility had basically two hours or less to report it to the state. CNA E stated she looked for the SSD but could not find him and did not think the NHA was in the building. She acknowledged the NHA's phone number was posted and agreed it was her responsibility to report the allegation directly to the NHA but did not do so. 2. Review of resident #9's medical record revealed he was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including right femur fracture, end stage renal disease, and type 2 diabetes. Review of a Progress Note dated 5/07/26 revealed resident #9 had a BIMS score of 14 out of 15, indicating intact cognition. Review of the Nursing Home Federal Report Form submitted to AHCA on (continued on next page)		

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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Aviata 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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/08/26 revealed an allegation of mental/verbal abuse occurring on 5/01/26 at 2:51 PM. The report documented Registered Nurse (RN) D became aware of the allegation on 5/03/26 and NHA was not notified until 5/04/26. Review of a Complaint/Grievance Report dated 5/04/26 documented resident #9 reported concerns regarding the behavior of a staff member who, according to the resident, addressed him in a very inappropriate manner. The grievance was communicated to the SSD and was classified as customer service rather than an allegation of abuse. On 7/08/26 at 10:24 PM, during a telephone interview, RN D in regard to resident #9's allegation of verbal abuse on 5/01/26, she stated she overheard a verbal altercation between CNA H and resident #9. She indicated she asked the resident what he wanted to do because she was not his assigned nurse. RN D recalled later completing a witness statement but could not recall whether she reported the incident directly to the NHA. She stated she heard CNA H ask resident #9, Why did you report my daughter? and use profanity toward the resident. RN D acknowledged she recognized the incident was serious and knew it should be reported. The nurse stated she did not know who served as the facility's Abuse Coordinator. On 7/09/26 at 11:23 AM, CNA E stated she cared for resident #9 on 5/02/26 and 5/03/26. She indicated resident #9 told her a CNA had said very horrible things to him, threatened to bring her family to the facility, and told him, Oh you do not know who my family is. CNA E stated resident #9 also reported the CNA cursed at him and threatened him. She recalled she overheard resident #9 discussing the incident with other residents while RN D was present. CNA E stated she asked RN D if the incident had really occurred and whether it had been reported. CNA E remembered, RN D responded it had been reported. Review of the CNA Assignment sheets dated 5/01/26 and 5/02/26 revealed CNA H was assigned to work the 11:00 PM to 7:00 AM shift on both dates. Review of CNA H's timecard for the payroll period from 4/23/26 through 5/06/26 confirmed she worked on 5/02/26 from 11:18 PM to 7:20 AM and on 5/03/26 from 11:20 PM to 7:22 AM. On 7/09/26 at 3:35 PM, the NHA stated RN D overheard the conversation between CNA H and resident #9 on 5/01/26 but did not report the incident to her until 5/04/26. The NHA provided a grievance form she completed on 5/04/26 after receiving a text message from RN D stating the nurse overheard the CNA H using obscenities toward resident #9. The NHA stated the text message did not include detailed information, so she contacted RN D for clarification. According to the NHA, RN D told her to just ask him, that conversation wasn't right, and stated she may have misinterpreted what she heard. The NHA stated she was under the impression it was not as the nurse stated, in regard to why she had not submitted an immediate report to AHCA on 5/04/26, as soon as she became aware of the allegation. The NHA acknowledged she did not ask RN D why the incident had not been reported on the day it occurred. She further acknowledged resident #9 remained exposed to the alleged perpetrator for approximately two additional days before the employee was suspended. The NHA stated CNA H was not assigned to care for resident #9. She explained the incident occurred in the hallway while another CNA was nearby. The NHA acknowledged neither RN D, CNA H, nor the other CNA reported the allegation to her until RN D sent the text message on 5/04/26, the same day resident #9 filed a grievance with the SSD. Review of a Witness Statement completed by RN D on 5/06/26 read, On 1 May 2026 I was in the subacute hallway when the CNA (CNA H's name) and a patient were having a conversation next to me. At that time I heard her say to the patient, Don't (explicit word) with me. You don't want me to bring my family! Review of resident #9's Witness Statement obtained by the SSD on 5/08/26 read, Met with resident in SSD' office to address resident's concern. He stated, On Friday, May 1, 2026, I asked the CNA (CNA I's name) why didn't she take out the trays. I had my breakfast and lunch tray in the room at the same time they were bringing in my dinner tray. She said I had to wait, with a bad attitude. Yes, she kept on walking while I was talking to her. (Name of Unit Manager) went to talk with her after I spoke with (continued on next page)		

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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Aviata 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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	SSA (Social Services Assistant). Later that day, her mom came to talk to me. She came up to me, pointed in my face and told me not to mess around with her daughter. She then said, f- -k you. I told her all I did was file a complaint with Social Services about the trays. Her mom told me she will bring her family if I had any problems. I just told her that I had family too. She left me and went to speak with another CNA. Review of the facility's Complaint/Grievance policy, revised 10/24/22, revealed residents had the right to voice grievances without fear of discrimination of reprisal. The policy documented grievances meeting the definition of abuse, neglect, exploitation, or misappropriation would be handled in accordance with the facility's Abuse Policy. Review of the facility's Abuse, Neglect, Exploitation & Misappropriation policy, revised 11/16/22, revealed all reported events were be investigated by the DON or designee, with information forwarded to the Executive Director, who served as the Abuse Coordinator. The policy included the Abuse Coordinator was responsible for investigating all reports and allegations of abuse, neglect, exploitation and misappropriation. Immediately upon an allegation of abuse, neglect, exploitation and misappropriation, including obtaining statements from the alleged victim, the alleged perpetrator, and potential witnesses. The policy further required any employee or contracted service provider who witnessed or had knowledge of an act or an allegation of abuse, neglect, exploitation or mistreatment, or misappropriation to report the information immediately, but no later than two hours after the allegation was made if the event involved abuse, or no later than 24 hours if the event do not involve abuse and did not result in serious bodily injury, to the Administrator and other officials in accordance with State law. The policy described in the absence of the Executive Director, the DON served as the designated Abuse Coordinator.		

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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Aviata 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)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to conduct thorough investigations of a resident-to-resident physical abuse allegation resulting in injury and a staff-to-resident verbal abuse allegation for 2 of 5 residents reviewed for abuse, of a total sample of 15 residents, (#2 and #9). Findings: 1. Review of resident #1's medical record revealed he was initially admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included schizophrenia, major depressive disorder, anxiety, and anoxic brain damage. Review of the quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 6/13/26 revealed resident #1 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicating severe cognitive impairment. Review of a Behavior Progress Note dated 5/04/26 revealed resident #1 was constantly going into other resident's rooms. The note documented that when staff attempted to redirect him to his room, the resident planted his feet firmly on the floor as he did not want to return. The documentation indicated staff redirected him several times during the shift, and the Social Worker was notified of the behavior. Review of a Progress Note dated 5/10/26 revealed resident #1 exhibited severe behavioral disturbances throughout the shift, including refusal of care, combative behaviors toward staff, and repeated attempts to enter other residents' rooms. Despite multiple redirections, interventions, and behavioral approaches, resident #1 continued exhibiting intrusive wandering behaviors and remained difficult to redirect for extended periods. The note indicated continued monitoring and behavioral interventions were maintained to promote resident and unit safety. Review of a provider Progress Note dated 5/13/26 revealed resident #1 was evaluated for behaviors. The provider documented the resident was sitting up in bed, had been acting out, attempting to get out of bed, and refusing medications. Review of a Progress Note dated 5/17/26 revealed at approximately 3:05 AM, officers met with resident #1. The note indicated the resident was not [NAME] Acted by officers, and the officers were aware of an occurrence where resident #1, physically attacked another resident causing harm. Provider made aware that resident was not baker acted by officers, Guardian made aware of recent events involving resident. Staff continues to monitor resident with enhanced supervision. 2. Review of resident #2's medical record revealed she was initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included chronic obstructive pulmonary disease, functional quadriplegia, adjustment disorder, and anxiety. Review of the admission MDS assessment with an ARD of 6/26/26 revealed resident #2 had a BIMS score of 15 out of 15, indicating intact cognition. Review of resident #2's Progress Note dated 5/17/26 revealed that, at approximately 2:45 AM, resident #2 approached the nurses' station in her wheelchair and reported resident #1 had entered her room and punched her in the face. The note further documented resident #1 was observed at end of the hallway and redirected by staff. Resident #2 complained of pain to her left jaw and the right side of her face, and staff noted a knot-like area on the right side of her face. Review of a Social Services Progress Note dated 5/18/26 revealed the Social Services Director (SSD) met with resident #2 to assess her well-being following the incident. Resident #2 stated, I'm doing okay. It was about 2:30 AM when this guy walked into my room. I was asleep when he entered. I was awakened by his presence. I yelled at him to leave the room. He walked towards the door then turned back towards me. This happened about 5 times. All he said to me was that this was his room. Yes, he walked towards me and was going away at my face. Yes, I had the call light on, and I was yelling for help. He closed the bathroom and room door. I am not sure how long he was in the room. The door was ajar and not fully closed. After he left, I got into my wheelchair and went to the Nursing Station for help. On 7/08/26 at (continued on next page)		

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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Aviata 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)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12:12 PM, resident #2 stated that resident #1 entered her room, sat at the foot of her bed, and began pulling her blankets. She stated she repeatedly asked resident #1 to leave but he refused. Resident #2 stated she activated her call light and attempted to pull her blankets back, at which time resident #1 punched her in the face with a closed fist. She reported staff did not respond to her repeated calls for help, so she transferred herself into her wheelchair and went to the nurses' station. Resident #2 stated she observed a Certified Nursing Assistant (CNA) asleep in the day room and recalled a nurse jokingly saying he was also asleep. Resident #2 stated she told the nurses she had been yelling and screaming for assistance while resident #1 remained in her room repeatedly saying, my bed, my bed, leading her to believe he thought he was in his own room. Resident #2 stated resident #1 walked toward the door several times but repeatedly returned instead of leaving. Resident #2 further stated resident #1 had entered other residents' rooms before coming into hers. She showed photographs of the bruising to her face following the incident and recalled it took a nurse and two CNAs to remove resident #1 from her room. Resident #2 stated she did not sustain any fractures but experienced significant facial pain. On 7/08/26 at 2:20 PM, resident #14 stated she recalled resident #1 entering her room and slamming the door. She stated she called the nurses' station after hearing another resident screaming for help for approximately 15 minutes. Resident #14 stated the incident lasted more than 20 minutes and resident #2 eventually went to the nurses' station in her wheelchair to seek assistance. She stated resident #2, whose room was across from hers, repeatedly screamed stop during the incident. Resident #14 further stated resident #2's face remained bruised for weeks following the incident. On 7/08/26 at 5:21 PM, resident #6 stated she learned about the incident involving resident #2 after receiving a text message from resident #2 that same night. She further stated the incident made her very afraid and remained fearful; because she believed something similar could happen to her. Resident #6 indicated resident #1 was able to walk throughout the hallways without staff intervening, despite nurses being present at the nurses' station. She stated resident #2 had been screaming for help and ultimately had to go to the nurses' station herself to obtain assistance. Resident #6 reported she had heard there was not CNA present on the unit at the time of the incident and mentioned staff were not as attentive during the night shift. Resident #6 further stated no one interviewed her regarding what she knew about the incident. On 7/09/26 at 3:35 PM, the Administrator (NHA) reviewed the investigation regarding the resident-to-resident physical abuse allegation involving residents #1 and #2. The NHA stated resident #1 had no history of aggression toward other residents but acknowledged he had a history of aggression involving objects. She indicated resident #1 remained on one-on-one (1:1) supervision following the incident, laboratory work was obtained, medications were reviewed, and the interdisciplinary team discussed interventions, including room placement, medications and supervision. She stated the facility attempted to transfer resident #1, however, his guardian wanted him to remain in the facility because it was closer to her. The NHA further stated the Director of Nursing (DON) completed the chart review and Progress Notes from 4/21/26 to 5/22/26 were printed as part of the investigation. However, the NHA confirmed the investigation did not identify or include the Behavior Progress Notes dated 5/04/26 and 5/10/26 documenting resident #1 repeated attempts to enter other residents' rooms, intrusive wandering behaviors, and difficulty with redirection during the week preceding the incident. The NHA stated the investigation included three witness statements consisting of a Social Services Progress Note on 5/18/26, an interview with Licensed Practical Nurse (LPN) C, and from a CNA who provided 1:1 supervision for resident #1 after the incident. The NHA indicated she and the SSD interviewed other residents, and no one reported hearing or witnessing the incident. The investigation file contained no evidence the staff assigned to resident #1, other staff working the unit the night of the incident, or (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Aviata 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)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents occupying nearby rooms were interviewed. The NHA acknowledged she could not identify which staff or residents had been interviewed the night of the incident and stated interview forms were not available to support those interviews. She further stated no one reported resident #1 had attempted to enter other residents' rooms before entering resident #2's room. 3. Review of resident #9's medical record revealed he was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including right femur fracture, end stage renal disease, and type 2 diabetes. Review of a Progress Note dated 5/07/26 revealed resident #9 had a BIMS score of 14 out of 15, indicating intact cognition. Review of the Agency for Health Care Administration (AHCA)'s Nursing Home Federal Report Form, submitted on 5/08/26, revealed an allegation of mental/verbal abuse involving resident #9 occurred on 5/01/26 at 2:51 PM. The report documented Registered Nurse (RN) D became aware of the allegation on 5/03/26 and the NHA was notified on 5/04/26. Review of resident #9's witness statement, obtained by the SSD on 5/08/26, revealed resident #9 stated, On Friday, May 1, 2026, I asked the CNA (CNA I) why didn't she take out the trays. I had my breakfast and lunch tray in the room at the same time they were bringing in my dinner tray. She said I had to wait with a bad attitude. Yes, she kept on walking while I was talking to her. (Unit Manager's name) went to talk with her after I spoke with SSA (Social Services Assistant). Later that day, her mom came to talk to me. She came up to me, pointed at my face and told me not to mess around with her daughter. She then said, f-k you. I told her all I did was file a complaint with Social Services about the trays. Her mom told me she will bring her family if I had any problems. I just told her that I had family too. She left me and went to speak with another CNA. On 7/09/26 at 3:35 PM, the NHA reviewed the investigation regarding the allegation of verbal abuse involving resident #9. The NHA stated the Unit Manager no longer worked at the facility and acknowledged the investigation file did not contain a statement from him. She further stated the investigation file did not contain a statement from the Social Services Assistant. The NHA stated the SSD interviewed resident #9 on 5/08/26, and the reportable event was submitted that same day. She stated CNA I was not assigned to resident #9. The NHA acknowledged she did not interview residents who were present in or near the hallway where the incident occurred because she did not know if ay residents had witnessed the event. Review of the facility's Abuse, Neglect, Exploitation & Misappropriation policy, revised 11/16/22, revealed all reported events were be investigated by the DON or designee, with information forwarded to the Executive Director, who served as the Abuse Coordinator. The policy stated the Abuse Coordinator was responsible for investigating all reports and allegations of abuse, neglect, exploitation and misappropriation. The policy further required the Abuse Coordinator and/or the DON to conduct a thorough investigation by obtaining statements from the alleged victim, the alleged perpetrator, and all potential witnesses, including employees who were in the vicinity of the alleged incident. In the absence of the Executive Director, the DON served as the designated Abuse Coordinator. The policy also required allegations of abuse, neglect, exploitation, and misappropriation to be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) program. The QAPI committee was responsible for evaluating the thoroughness of the investigation, measures taken to protect the resident, identified risk factors, the root cause of the incident, and any systemic changes necessary to prevent recurrence.		

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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Aviata 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)		
F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a Compliance and Ethics Program. Based on interview, and record review, the facility failed to effectively implement its compliance and ethics program by failing to promote ethical conduct related to reporting resident incidents and allegations of abuse, failing to provide effective oversight by high-level personnel to ensure adherence to ethical standards, and failing to maintain effective lines of communication that encouraged staff and residents to report concerns without fear of retaliation. Findings: On 7/08/26 at 2:50 PM, resident #4 stated the Director of Nursing (DON) yells at everybody and has nurses here crying. She stated a visitor had reported the DON to Corporate because the DON discussed other residents in front of residents and visitors. Resident #4 further stated staff were disrespectful toward Spanish-speaking residents, and some residents feared retaliation and therefore did not report their concerns. On 7/08/26 at 5:21 PM, resident #6 stated some residents were afraid to report concerns to staff because they feared retaliation. Resident #6 said, if you talk to someone, there's a lot of repercussions here, even from staff talking. On 7/08/26 at 9:27 PM, during a telephone interview, Licensed Practical Nurse (LPN) C stated she was concerned facility management changed staff statements and later claimed they were unaware of reported incidents. She further stated the facility was underreporting all the time. LPN C stated the DON instructed staff what to write to cover up incidents. She indicated nurses documented medications as administered when they were not even available to be given and staff were required to contact the DON before initiating any cardiopulmonary resuscitation, which could delay care. LPN C stated there was a lot of retaliation to the staff. On 7/08/26 at 10:24 PM, during a telephone interview, Registered Nurse (RN) D said, It is too much happening in the facility. Not sure if people are doing the right thing. RN D indicated the DON had insulted her and made comments such as Why are you with Hispanics? She stated staff was afraid of the DON because she screamed and yelled at them. RN D further stated residents had videotaped the DON yelling at her and later told her they were tired of the way the DON treated the staff. She stated someone from the corporate office contacted her regarding the video and instructed her to report the matter to Human Resources (HR). RN E stated she believed the DON's actions were retaliatory. On 7/09/26 at 10:35 AM, CNA J stated he was unaware of the facility's ethic and compliance telephone number and believed concerns should be reported to HR. CNA J further stated he was not familiar with the facility's ethics and compliance program. On 7/09/26 at 11:03 AM, Licensed Practical Nurse (LPN) F stated she was unsure whether she had completed the facility's ethics and compliance training. She indicated she would report required incidents to the Administrator (NHA) and grievances to the Social Services Director (SSD). However, LPN F was unable to explain when or how the facility's ethics and compliance line should be used. She stated ethics meant treating people with respect and not calling them names. On 7/9/26 at 11:23 AM, CNA E stated residents should be treated with dignity and respect, but she had observed several nurses speak to residents in a disrespectful manner, including telling residents, Go to your room. She stated she was afraid to report concerns because she feared losing her job. She stated she previously informed the NHA about the manner the DON reprimanded her in front of staff and residents. CNA E explained this was the reason she sought assistance from Social Services when residents voiced concerns rather than reporting directly through nursing leadership. On 7/09/26 at 3:12 PM, the NHA acknowledged staff had expressed concerns regarding the DON's behavior, including that the DON spoke harshly to staff and had been rough in her interactions. The NHA stated she discussed those concerns with the DON and described herself as serving as a mediator because the DON was passionate about getting stuff done. The NHA stated she had not reported those concerns to corporate leadership. She indicated staff received (continued on next page)		

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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Aviata 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)		
F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ethics and compliance education upon hire, and annually; for example, during staff meetings she reminded employees, if you see or hear something, say something. The NHA stated she was unaware, staff or residents, feared retaliation and reiterated staff could report concerns directly to her or though the corporate compliance hotline if they were uncomfortable reporting to their supervisor. On 7/09/26 at 5:19 PM, during a telephone interview, the Corporate Compliance Officer stated she monitored the corporate compliance hotline, which accepted anonymous and identified reports from staff, residents, family members, or community members. She explained concerns could also be submitted electronically through a QR code and categorized as employee concerns, abuse concerns, fraud, billing issues, or other compliance matters. She stated employees completed ethics and compliance training upon hire and annually, with training available in multiple languages. She explained the training concluded with a competency test and employee attestation. The Corporate Compliance Officer stated one compliance concern had been received that morning regarding a medication issue and assigned to the facility for follow up. She indicated the company received five compliance concerns during 2025 and two during 2026 to date. The Corporate Compliance Officer mentioned employee concerns were tracked separately through HR. She explained corporate oversight was provided by regional leadership through routine operational and clinical visits, and all concerns were forwarded to the Regional [NAME] President of Operations. Lastly, she stated she was also the Chief Nursing Officer, and the company took all compliance concerns seriously. Review of an undated Corporate Compliance poster hung near the staff clock in area, revealed the program was their code of business conduct. The poster instructed the reader that if they were faced with an issue or were aware of an issue that may be illegal or unethical the staff were expected to make that issue known. The poster indicated the expectation that all employees were aware of and should abide by all federal and state rules and regulations. The document described ongoing training and regular audits would be conducted to confirm compliance. The bottom of the poster detailed in bold, If you have any compliance concerns, please contact our Corporate Compliance Hotline, with a phone number in large letters at the bottom. (Photo evidence obtained) Review of the facility's Corporate Compliance Program, revised 9/01/23, revealed the company was committed to maintaining the highest ethical standards and complying with applicable federal and state laws and regulations. The policy stated the goals of the compliance program included preventing and correcting fraud, waste and abuse; promoting a culture of ethical behavior and compliance; and providing quality care to residents. The policy further identified seven elements of an effective compliance program, including written policies and procedures, compliance by a Corporate Compliance Officer and Compliance Committee, effective education and training, auditing and monitoring, open lines of communication, consistent disciplinary standards, and corrective action Review of the facility's Ethics, Conflict of Interest policy, revised 9/01/23, revealed all employees were required to comply with applicable federal, state, and local laws, rules, and regulations governing the company's operations. The policy included employees were responsible for reporting suspected ethical misconduct.		

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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Aviata 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)		
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess whether a resident could safely self-administer medications and implement the required process for self-administration for 1 of 1 residents reviewed for self-administration of medications, out of a total sample of 15 residents, (#3). Findings: Review of resident #3's medical record revealed he was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including congestive heart failure (CHF), atrial fibrillation, hemiplegia (one-sided paralysis) and hemiparesis (one-sided muscle weakness) following a stroke affecting the right dominant side, and type 2 diabetes. Review of the Minimum Data Set quarterly assessment with an Assessment Reference Date of 5/04/26 revealed resident #3 had a Brief Interview for Mental Status score of 15 out of 15 which indicated intact cognition. On 7/08/26 at 10:50 AM, resident #3 stated he was scheduled for a surgical procedure the following day and had been instructed to hold his blood thinning medication, Eliquis beginning Sunday. He indicated the staff still administered the Eliquis on Monday and Tuesday morning but he did not take the medication. The resident unwrapped a piece of aluminum foil he kept next to his bed and showed four medications he had retained instead of taking: two Eliquis tablets, one Digoxin tablet, and one Doxycycline tablet. He stated some nurses left medications at his bedside for him to take later. Resident #3 explained had he not recognized the medications, he could have taken the Eliquis, resulting in cancellation of his scheduled procedure. He stated the medications he retained included one Eliquis tablet from Monday, one Eliquis tablet from Tuesday, and the Doxycycline and Digoxin tablets administered Tuesday. The resident further stated he intended to return the medications to the evening nurse, but the nurse instructed him to keep them instead. He stated nurses did not always read the physician's orders, and some became upset when he asked questions about his medications, even when he asked to be informed of what medications he was receiving. On 7/08/26 at 11:28 AM, Registered Nurse (RN) B entered resident #3's room and confirmed she was his assigned nurse. She stated she had not administered any medications to him that morning because the medications had already been given by the previous shift nurse. RN B confirmed the medications resident #3 had retained, then stated the resident was not supposed to have medications in his possession. She said she had no knowledge he was keeping medications at his bedside. Resident #3 told RN B she had administered one of the Eliquis tablets to him previously, which RN B denied. She stated she always remained with the resident until he swallowed his medications and, if he refused medications, she discarded them in the Drug Buster. On 7/08/26 at 11:38 AM, the Director of Nursing (DON) entered resident #3's room. She stated nurses always administered medications directly to residents and was unaware resident #3 had medications in his possession. Resident #3 told the DON if he had taken the Eliquis provided to him by the nurses, he could have experienced serious bleeding during his scheduled surgery. The DON stated she was aware the resident refused a lot of medications, but repeated she was unaware he retained medications in his possession. Review of resident #3's Admission/readmission Data Collection nursing evaluation dated 6/17/25 revealed a medication review was completed. Question number one asked whether the resident self-administered medications and was answered No. The form instructed staff if the answer was Yes, a Self-Administration Evaluation was to be completed. There was no evidence a Self-Administration Evaluation had been completed. Review of resident #3's care plan included focuses for anticoagulant therapy and CHF, initiated on 11/14/25, and antibiotic therapy, revised on 7/02/26. Interventions directed nurses to administer the medications as ordered by the physician. There was no care plan (continued on next page)		

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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Aviata 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)		
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	addressing self-administration of medications. Review of resident #3's July 2026 Medication Administration Record (MAR) revealed:*Digoxin 125 micrograms scheduled for 9:00 AM was documented as administered on 7/05 and 7/07 by Licensed Practical Nurse (LPN) F and on 7/06 and 7/08 by RN B.*Doxycycline 100 milligrams (mg) scheduled for 9:00 AM was documented as administered on 7/05 and 7/07 by LPN F and on 7/06 and 7/08 by RN B.*Doxycycline 100 mg scheduled for 9:00 PM was documented as administered on 7/05, 7/06, 7/07 by RN G. *Eliquis 5 mg scheduled for 9:00 AM and 9:00 PM was last documented as administered on 7/05 by LPN F. On 7/09/26 at 11:03 AM, LPN F stated resident #3 chose which medications he wanted to take each day. She confirmed she cared for him on Sunday, 7/05/26, and Tuesday, 7/07/26, from 7:00 AM until 7:00 PM. LPN F stated she observed resident #3 take his medications. She recalled that, sometime previously, resident #3 had asked her to leave his medications at the bedside because he did not want staff watching him take them. She stated she informed him facility policy required staff to observe residents taking their medications, which upset him. LPN F mentioned that after that conversation, the resident understood he was required to take his medications in her presence. She further stated the resident never told her another nurse had left medications at his bedside. On 7/09/26 at 2:21 PM, an attempt to interview RN G, the assigned evening nurse for resident #3's on 7/05/26, 7/06/26, and 7/07/26 was unsuccessful. Later, on 7/09/26 at 5:53 PM, the DON stated she could not explain how resident #3 came to have four medications in his possession. She indicated she had spoken with the nurses who cared for him during the month, and each reported they had not left medications at the bedside. The DON confirmed nurses were not permitted to leave medications unattended because anyone entering the room could access them. The DON acknowledged there was no physician order authorizing resident #3 to self-administer medications, no completed self-administration evaluation, no interdisciplinary team approval, no MAR identification of self-administered medications, and no locked bedside storage for the medication. Review of the facility's Self-Administration of Medications at Bedside policy, revised 8/22/17, revealed residents could keep medications at the bedside for self-administration only after meeting established criteria. The policy required verification of physician's order authorizing self-administration of specific medications, completion a Self-Administration Evaluation, interdisciplinary team review and approval, development of a care plan for approved self-administered medications, quarterly reassessment and reassessment with any change in condition, documentation on the MAR identifying medications approved for self-administration, nursing follow up regarding medication documentation and storage during each medication pass, and storage of bedside medications in a locked drawer. Review of the facility's Administering Medications policy, revised April 2019, revealed medications were to be administered safely, timely, and as prescribed. Staff administering medications were required to initial the resident's MAR after administering each medication and before administering the next medication. The policy further stated residents may self-administer medications only after the attending physician, in conjunction with the Interdisciplinary Care Planning Team, determined the resident had the decision-making capacity to safely self-administer medications.		

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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Aviata 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)		
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure accurate documentation of the clinical record for one of two residents reviewed for medication administration documentation, of a total sample of 15 residents, (#4). Findings: Review of resident #4's medical record revealed she was admitted to the facility on [DATE] with diagnoses including gastritis, anxiety disorder, major depression disorder, and osteoarthritis. Review of the admission Minimum Data Set assessment with an Assessment Reference Date of 6/16/26 revealed resident #4 had a Brief Interview for Mental Status score of 15 out of 15 indicating intact cognition. Review of resident #4's Medication Administration Record (MAR) for July 2026 revealed resident #4 had physician orders for MiraLAX Oral Powder 17 grams, reconstituted, given twice a day. On 7/08/26 at 10:47 AM, during the facility tour resident #4 approached in her wheelchair and requested to meet in her room to discuss a concern. Later at 2:53 PM, in the resident's room, she recalled events from 7/01/26 when she said License Practical Nurse (LPN) B gave her a medication cup that contained MiraLAX and two unidentified pills inside. Resident #4 stated upon noticing the pills inside the MiraLAX liquid she questioned LPN B about what the two pills were and why they were inside the MiraLAX. Resident #4 explained she spit out the pills and did not take the MiraLAX. She recalled LPN B took the medication cup away from her and said the pills were vitamins to make her stronger. Resident #4 stated this made her upset and she requested to speak with the Director of Nursing (DON) which led to a verbal confrontation between LPN B and the resident. On 7/09/26 at 1:53 PM, LPN B stated she did not administer the dose of MiraLAX on 7/01/26 at 5:00 PM to resident #4. She confirmed the documented 7/03/26 at 9:00AM dose of MiraLAX was actually given by another nurse. LPN B stated the documentation on the July MAR was wrong and confirmed it was erroneous. The nurse explained she did not see resident #4 after the incident on 7/01/26. Further review of the July 2026 MAR revealed LPN B documented on 7/01/26 at 5:00 PM, that resident #4 received MiraLAX when the resident did not actually receive the medication. On 7/03/26 LPN B documented she administered the medication to resident #4 when actually another nurse administered the medication. On 07/09/26 at 5:45 PM, the DON stated nurses were expected to document medication administration accurately at the time medications were administered, and that medication administration record should reflect whether medication was given or refused. The Director of nursing stated the nurse that gave the medication should be the nurse who documented the medication administration.		

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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Aviata 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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to adhere to infection prevention and control practices related to glove use, handling of soiled waste, and hand hygiene. Findings: On 7/08/26 at 11:47 AM, Certified Nursing Assistant (CNA) A came out a resident room and was walking in the hallway on her way to the soiled utility room. The CNA was wearing a glove on her left hand and holding plastic bags to take to soiled utility room. On 7/08/26 at 11:50 AM, CNA A stated she was new at the facility but had received training by computer and in person on infection control and prevention. CNA A confirmed she was not supposed to wear gloves in hallway. The CNA stated she wore the glove into the hallway because there was a lot of stool and urine in the trash. CNA A stated she should not wear gloves in hallway because the glove could spread infection. On 7/09/26 at 5:45 PM, the Director of Nursing stated staff were expected to remove gloves after completing resident care and perform hand hygiene after glove removal. She confirmed gloves were not to be worn in the hallway so as not to spread infection and to prevent cross contamination. Review of the Personal Protective Equipment (PPE) policy revised October 2018 revealed gloves were part of the PPE provided to protect staff from exposure to bodily fluids. Review of the undated, US Centers for Disease Control and Prevention, Sequence for Putting on PPE, revealed, Remove all PPE before exiting the patient room, (retrieved from www.cdc.gov on 7/22/26).		