

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

Printed: 07/18/2026
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 09/18/2025
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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observation, interview, and record review, the facility failed to maintain an effective Quality Assurance and Performance Improvement (QAPI) program by not identifying and addressing repeated deficiencies and by not ensuring complete monitoring documentation for corrective action plans. The deficient practice resulted in a pattern of unresolved quality concerns and had the potential to affect more than a limited number of residents by not ensuring consistent monitoring and follow-up of identified problems. Findings: On a previous survey dated 4/26/24, Centers for Medicare & Medicaid Services (CMS) Enforcements were issued that included: F0656 (Develop/Implement Comprehensive Care Plan), F0695 (Respiratory/Tracheostomy Care and Suctioning), and F0759 (Free of Medication Error Rate of 5 Percent or More). On 9/18/25 at 2:14 PM, the Nursing Home Administrator (NHA) explained their QAPI program included a four-step process with: identification of deficient practice, investigation of problem causes, correction of problems, and development of correction plans with goals, timelines, and education with retention tools, and audits to determine effectiveness. A joint review of the facility's Performance Improvement Plans (PIPs) since the last recertification was conducted with the NHA and Director of Nursing (DON). Documentation of monitoring for previously identified deficiencies with F0695 was incomplete or missing. For example, on 1/28/25, the facility identified a supplemental oxygen dependent resident in a state of lethargy (fatigue/sluggishness) and without the physician's ordered oxygen. The facility conducted an Ad Hoc (when necessary) QAPI meeting where the committee developed a PIP to ensure residents received supplemental oxygen per physician's orders that included daily checks and weekly audits. When asked to review the monitoring documentation and audits, the DON stated, we don't really have a track and trend record; we do it daily and keep a mental record; it's ongoing. From 9/15/25 to 9/18/25, a recertification survey was conducted, and deficient practice was again identified for F0656 (Develop/Implement Comprehensive Care Plan), F0695 (Respiratory/Tracheostomy Care and Suctioning), and F0759 (Free of Medication Error Rate of 5 Percent or More). The facility did not implement an ongoing, systematic QAPI program to ensure that identified problems were corrected and prevented from recurring. The failure of the facility to maintain complete monitoring documentation and address repeated deficiencies demonstrated that the QAPI program was not effective. Review of the facility's undated standards and guidelines titled 2025 QAPI Plan noted the facility was committed to using QAPI to improve performance and practices and assure regulatory standards were met or exceeded. The PIP projects process outlined that plans included goals, actions, target dates, and status/outcomes. The standards noted completed PIPs are filed in the QAPI notebook and monitored periodically to assure achievements are being sustained.		

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to conduct thorough, periodic reviews of Advance Directives to ensure resuscitation status related to Do Not Resuscitate (DNR) orders was accurately documented in the medical record to effectively communicate choices regarding withholding life-sustaining measures for 1 of 1 residents reviewed for Advance Directives, of a total sample of 43 residents, (#33). Findings: Review of the medical record revealed resident #33 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including cerebral atherosclerosis (hardening of brain arteries), severe vascular dementia with agitation, brain bleed, major depressive disorder, restlessness and agitation. Review of hospice paperwork revealed resident #33 was admitted to hospice on 4/30/25 with a primary terminal diagnosis of cerebral atherosclerosis. The document indicated resident #33 was at the facility for respite care from 5/30/25 till 6/04/25. A progress note dated 6/10/25 at 4:42 PM, revealed the resident was re-admitted to the facility from home with a hospice representative for inpatient respite care. Resident #33's electronic medical record (EMAR) revealed a Do Not Resuscitate (DNR) Order dated 5/01/25 which was signed by the resident's husband. A Do Not Resuscitate Order (DNRO) - Form 1896 was developed by the State of Florida Department of Health (DOH) to identify people who do not wish to be resuscitated in the event of respiratory or cardiac arrest. In order to be legally valid this form MUST be printed on yellow paper prior to being completed. [Emergency Medical Services] and medical personnel are only required to honor the form if it is printed on yellow paper, (retrieved on 9/20/25 from www.floridahealth.gov). Review of the resident's physician's order revealed an active order for Do Not Resuscitate with a start date of 5/30/25. Review of the resident care plan revealed the resident had a care plan for advanced directives related to DNR as evidence by DNR order initiated on 6/19/25. A progress note dated 6/11/25 at 4:06 PM, revealed a state agency investigator visited the facility to inform them that the state was exploring guardianship and long-term placement for resident #33. Review of a court order from the state of Florida dated 6/20/25 revealed the court determined resident #33 lacked capacity to consent to services and was a vulnerable adult in need of emergency protective services. The document also revealed that, no person shall honor any DNR related to the respondent. Such matter must be brought before the court. A court order dated 8/15/25 revealed the resident would remain at the facility due to a return home being inappropriate at that time. The document indicated the resident would remain in protective supervision by the agency for an additional 60 days. The document also detailed that no person shall honor any DNR related to the respondent. Such matter must be brought before the court. On 9/18/25 at 11:48 AM, the Administrator confirmed the facility incorrectly listed DNR as resident #33's code status in her medical record. She conveyed the resident should be a Full Code. The Administrator acknowledged she was ultimately responsible for coordinating the residents' care between the different agencies and the facility. The Administrator explained that although she read the court documents related to the resident, she surmised she did not read it thoroughly since she did not realize the resident's previous DNR order was nullified. She stated that while the facility reviewed advanced directives regularly, they failed to review the resident's medical record in its entirety and had looked solely at the DNR form and the physician order. The facility policy titled Advanced Directives revised on 11/14/18 revealed that advanced directives were to be reviewed quarterly and additional times as needed. The reviews were designed to identify situations where health care decision-making was needed and review the residents' condition. The policy detailed if upon notification from the resident or resident representative the desire to revoke an advanced directive, the physician would be notified, and the medical record would be modified accordingly.		

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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** Based on observation, interview, and record review, the facility failed to develop an individualized Comprehensive Care Plan to include actual skin impairments for 1 of 3 residents reviewed for pressure ulcers, of a total sample of 43 residents, (# 4). Findings: Review of resident #4's medical record revealed he was readmitted to the facility on [DATE] with diagnosis of cerebral infarction (stroke), stage three pressure ulcers- sacral region and right ankle, unstageable pressure ulcers- left ankle/right heel/right upper back and right/left buttocks. Review of resident #4's Quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date of 6/30/25 revealed the resident had severe cognitive impairment, was totally dependent on staff for all his activities of daily living, was at risk for pressure ulcers/injury, had four unhealed stage three pressure ulcers that he was admitted /readmitted to facility with, and had six unstageable pressure ulcers three of which he was admitted /readmitted with to the facility. Stage three pressure ulcer means full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage four pressure ulcer means full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling . Slough and/or Eschar in a pressure ulcer makes the wound unstageable due to coverage of wound bed by slough and/or eschar. Deep-Tissue Injury (DTI): Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. (Retrieved from Pressure Ulcer/Injury Coding Pocket Guide on 9/19/25). Review of resident #4's medical record revealed he did have comprehensive care plans in place for an indwelling urinary catheter, ineffective airway clearance, hospice, dependence on staff to meet emotional needs, dementia, communication problem, altered cardiovascular status, risk of falls, requires tube feeding, aspirin therapy, mood problem, risk of malnutrition and hemiplegia (one-sided paralysis). Resident #4 had a care plan revised on 5/20/24 for potential for pressure injury development, but the care plan did not mention any of the residents' actual pressure ulcers nor other alterations in his skin integrity. Review of resident #4's Wound Assessment Report dated 9/10/25 noted the following wounds with active orders: stage three pressure ulcer sacrum/right buttock acquired 5/17/22, stage three pressure ulcer left upper back acquired 5/29/25, stage three pressure ulcer spine acquired 6/18/25, stage four pressure ulcer left lateral ankle acquired 3/26/25, unstageable pressure ulcer right ischium acquired 4/30/25, Kennedy terminal ulcer right hip acquired 6/25/25, left medial ankle skin tear reopened 9/11/25, stage three pressure ulcer right lateral ankle acquired 3/11/25. There was a total of nine alterations in resident skin integrity that did not have a comprehensive care plan ever initiated with individualized interventions and person-centered goals. On 9/16/25 at 3:07 PM, assigned Certified Nursing Assistant (CNA) D was observed repositioning the resident and verified the resident had multiple wound dressings currently in place. Resident #4's active physician orders included wound care orders dated 9/04/25 for right flank, right ischium, right hip and right lateral ankle wounds. Orders dated 9/11/25 were for the sacrum/right buttock and left medial ankle. Orders dated 8/30/25 were for the spine, left upper back and left lateral ankle wounds. On 9/17/25 at 3:11 PM, an interview and concurrent record review was conducted with Assistant MDS Licensed Practical Nurse (LPN) and the Regional MDS nurse. The Assistant verified that resident #4 did not have any care plans to date for actual alterations in his skin integrity. The Assistant did not provide an explanation as to why they were not in place. The Regional MDS nurse said resident #4 should have comprehensive care plans for Potential for Alteration in Skin Integrity as well as Actual Alteration in Skin Integrity. The Regional nurse explained the care plans should be initiated and updated anytime a resident had pressure wounds, Kennedy ulcers or skin tears. The Regional MDS nurse validated there were no comprehensive care plans at this time to reflect the nine (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	areas of alteration in resident #4's skin integrity. The Regional nurse explained the care plans should have been initiated and/or updated when the quarterly MDS was completed on 6/30/25 by the Assistant MDS nurse. She reviewed the medical record and said that the MDS assistant did document that resident #4 had four stage three pressure ulcers and six unstageable pressure ulcers. All four of the stage three pressure ulcers were facility acquired and three of the unstageable wounds were also facility acquired. The Regional nurse said when the MDS assessment was completed the comprehensive care plan needed to reflect the current resident status regarding skin alterations. The Regional MDS explained since resident #4 was on hospice the goals could address that he had potential for getting wound infections and that wounds may not heal because he was on hospice and his overall health due to end of life. On 9/17/25 at 3:53 PM, the Director of Nursing (DON) said that resident #4 was admitted with wounds and the nurse should have initiated a comprehensive care plan for actual alteration in his skin upon admit/re-admit. The DON added that the care plan could have been initiated as well when the quarterly MDS was completed or at their morning meetings when they went over new wound care orders. Review of the facility's policy and procedure titled Plans of Care revised 9/25/17 read, An individualized person centered plan of care will be established by the interdisciplinary team (IDT).Develop a comprehensive plan of care for each resident that included measurable objectives and timetable to meet the resident medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.Review, update and/or revise the comprehensive plan of care based on changing goals .		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to conduct scheduled safety/risk evaluations for 1 of 1 resident reviewed for Smoking, (#53), of a total sample of 43 residents. Findings:Review of the medical record revealed resident #53, a [AGE] year old male was admitted to the facility on [DATE], and re-admitted from the hospital on 1/02/25 with diagnoses that included muscle weakness, pain in left shoulder, acquired absence of right upper limb above elbow (amputation), acquired absence of left leg above knee, acquired absence of right leg below knee, rotator cuff tear of unspecified shoulder, and polyneuropathy (nerve damage to arms and legs).The most recent Comprehensive Minimum Data Set (MDS) Significant Change Assessment with an Assessment Reference Date (ARD) of 6/27/25 noted resident #53 scored 15 out of 15 on the Brief Interview for Mental Status that indicated his cognition was intact. The assessment showed during the look-back period there were no behaviors or rejections of evaluation or care necessary to achieve health and well-being, the resident had functional limitations in Range of Motion (ROM) on one side of his upper extremities (shoulder, elbow, wrist, hand) and both sides of the lower extremities (hip, knee, ankle, foot). There was normally use of a wheelchair, and the resident required set-up/clean-up assistance for eating, supervision or touching assistance for oral hygiene, substantial/maximum assistance for dressing, and moderate/substantial assistance for personal hygiene and bathing. The resident was dependent on staff to transfer from the bed/chair/toilet and required moderate/maximum staff assistance to change positions in bed. During the look-back period, the resident received scheduled and as needed pain medications, he experienced 5 out of 10 (numeric rating scale) pain that occasionally interfered with day-to-day activities, and he received high-risk anti-depressant, opioid (narcotic pain), anti-platelet (clot prevention), and anti-convulsant (seizure) medications.The Care Plan Report included Focuses for: (3/21/25) Self-releasing safety belt for injury risk in a motorized mobility chair, (2/13/25) Activities of Daily Living (ADL) self-care deficits related to impaired functional mobility with right arm and both leg amputations, non-compliance with care, and smoker with goals that read, The resident will not suffer injury from unsafe smoking practices through the review date.On 9/15/25 at 3:16 PM resident #53 was sitting in a wheelchair in his room. The resident said he had lived at the facility for eleven years and did not recall any recent questions or assessments by staff about smoking safety. On 9/18/25 at 12:38 PM, resident #53 was sitting in a wheelchair in his room. The resident said he always smoked since he lived at the facility with the exception of a few days, several months prior when he was re-hospitalized for gastrointestinal problems.On 9/16/25 at 2:28 PM, Registered Nurse M said she knew resident #53 well and he was often included in her assignments when she worked both 12-hour shifts. The nurse said the resident always participated in smoke breaks.On 9/17/25 at 1:25 PM, the Director of Resident Experience said resident #53 actively participated in smoke breaks.On 9/18/25 at 10:17 AM, the Assistant MDS Licensed Practical Nurse checked resident #53's medical record and recalled the Significant Change assessment with the ARD of 6/27/25 was completed because the resident had a decrease in functioning, increased pain and limitations in his shoulder.Review of resident #53's medical record showed Smoking Evaluations were conducted quarterly from 1/11/22 until 2/16/25. No additional quarterly evaluations were completed that should have been due in May or August 2025, and an incomplete evaluation was opened on 9/18/25, the last day of the survey.On 9/18/25 at 9:50 AM, the Director of Nursing (DON) said she knew resident #53 well, and he had always been an active smoker. She explained nursing leadership was responsible for conducting smoking assessments. She said they were scheduled on admission/re-admission and quarterly to identify changes like increased weakness or impairments that required additional safety measures like a smoking apron to prevent burns. The DON checked the medical record and acknowledged resident #53 was missing smoking (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safety evaluations due in May and August 2025. She did not explain why they were not completed and stated, smoking safety is big, big, big, and we have to make sure they are safe; evaluations are important to do every three months. Review of the facility's standards and guidelines titled Smoking-Supervised dated 2/07/20 read, Residents that wish to smoke will be evaluated on admission/re-admission, quarterly, and with a change in condition to determine if assistance or supervision is required for smoking.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer Oxygen (O2) therapy as ordered by the physician for 2 of 3 residents reviewed for respiratory care, of a total sample of 43 residents, (#4 and #85). Findings: 1. Resident #4 was re-admitted to the facility on [DATE] with diagnoses of hemiplegia (one-sided paralysis) following cerebral infarction (stroke), pressure ulcers, and protein calorie malnutrition. Review of the Minimum Data Set (MDS) quarterly assessment with assessment reference date (ARD) of 6/30/25 revealed the resident had severe cognitive impairment. The MDS assessment noted the resident was dependent on staff assistance with dressing/personal hygiene care and received oxygen therapy. The assessment also noted that the resident did not exhibit behavior symptoms or rejection of care necessary to achieve the resident's goals for health and wellbeing. Review of resident #4's medical record revealed a care plan initiated on 3/31/25 which indicated a resident focus for Ineffective Airway Clearance/Aspiration due to SOB (shortness of breath) and use of 2 liters per minute (LPM) of oxygen continuously via nasal cannula. The goal was the resident would experience a clear airway with supplemental oxygen intervention. Review of resident #4's current active physician orders revealed an order for oxygen at 2 LPM via nasal cannula (NC) as needed (PRN) dated 5/02/25. On 9/15/25 at 10:50 AM, 1:50 PM, and 3:27 PM, resident #4 was lying in bed with O2 administered through a NC. Each time the O2 tubing was connected to an oxygen concentrator set at 1.5 LPM. 2. Resident #85 was re-admitted to the facility on [DATE] with diagnosis of chronic obstructive pulmonary disease (COPD), systemic lupus, hypertension, atrial fibrillation, anemia and chronic kidney disease. Review of the MDS quarterly assessment with ARD date of 6/24/25 revealed she had moderate cognitive impairment and did not receive oxygen therapy at the time the assessment was completed. The assessment also noted the resident was dependent on staff assistance with dressing/personal hygiene care and did not exhibit behavioral symptoms or rejection of care necessary to achieve the resident's goals for health and wellbeing. Review of resident #85's medical record revealed a care plan with focus for Oxygen Therapy for Shortness of Breath related to her diagnosis of COPD revised on 8/19/24. The goal was that she would not have signs and symptoms of poor oxygen absorption and interventions included staff to give medications as ordered by the physician and oxygen settings at 2 LPM via NC PRN for SOB. Resident #85's current active physician order dated 6/25/25 was for oxygen at 2 LPM via NC continuously and included instruction for nurses to check the oxygen delivery every shift. On 9/15/25 at both 11:01 AM, and 3:28 PM, resident #85 was lying in bed with O2 administered through a NC. The O2 tubing was connected to an oxygen concentrator set at 2.5 LPM. On 9/15/25 at 3:54 PM, Registered Nurse (RN) A explained she was assigned to residents #4 and #85 and she checked both of their oxygen saturation rates earlier today but forgot to check the concentrators to ensure they received the flow rate as ordered by the physician. RN A checked in the residents' electronic medical records and said they were both to be on 2 LPM of oxygen. RN A observed and acknowledged both residents #4 and #85 were not getting their oxygen as ordered. She was observed changing resident #4's oxygen from rate from 1.5 LPM to 2 LPM and resident #85's from 2.5 LPM to 2 LPM. Post observation she said that she was very tall, and it was difficult for her to read the concentrator at eye level. On 9/17/25 at 3:53 PM, the Director of Nursing (DON) said the nurses were supposed to check the oxygen liter flow rate at eye level at least every shift. The DON verbalized the expectation that nurses should check the physician's order and give what was ordered. The DON added best practice was for nurses to check the concentrator every time they went in the resident room to ensure they were getting O2 as ordered by the physician. Review of the facility's Oxygen Therapy policy and procedure revised 8/28/17 indicated, Procedure: Physician's order for oxygen therapy shall include. PRN orders must include specific guidelines as to when resident is to use oxygen. Review physician's order. Start O2 flowrate at the prescribed liter flow .		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were administered according to physician orders to prevent medication errors for 1 of 5 residents observed during the medication administration task, of a total sample of 43 residents, (#50). There were 2 errors in 32 opportunities for a medication error rate of 6.25%. Findings: Review of resident #50's medical record revealed she was admitted to the facility on [DATE] with diagnoses including heart disease, combined systolic and diastolic heart failure, heart muscle damage, hypertension, nicotine dependence, and stage 2 chronic kidney disease. On 9/16/25 at 9:04 AM, Registered Nurse (RN) C prepared resident #50's scheduled medications at her medication cart. She removed one tablet of chewable 81 milligrams (mg) Aspirin from the cart's stock medication bottle and placed it in a pill cup with the resident's other oral medications. RN C then removed a Nicotine patch (Step 2) 14 mg /24 hour (HR) from the cart. The nurse then proceeded to administer the Aspirin and place the Nicotine patch on the resident's left upper arm. Review of the resident's Electronic Medication Administration Record (EMAR) revealed resident #50 had a physician order for Aspirin 81 Oral Tablet Delayed Release 81 mg daily for pain with a start date of 8/16/23 and Nicotine Step 1 Patch 24 Hour 21 mg/24 HR daily for smoking cessation with a start date of 10/30/23. Delayed release (DR) medications are medications that are designed to release the active ingredients later after taking it. This can help control where the medication is released in the body, such as the small intestines. This is usually done to prevent the medication from breaking down too early or lessen potential side effects such as upset stomach, (retrieved on 9/19/25 from www.goodrx.com/drugs/medication-basics). On 9/16/25 at 11:15 AM, RN C failed to acknowledge the mistake of administering chewable aspirin instead of the delayed-release aspirin that was ordered by the physician. RN C confirmed she administered the Nicotine patch 14 mg instead of the 21 mg patch ordered by the physician. She explained, 14 mg was what was in the cart. On 9/17/25 at 1:26 PM, the Director of Nursing (DON) confirmed she was aware of the medication errors which she discussed with RN C. The DON said RN C had no explanation for why the errors had occurred. The DON stated her expectation was for nurses to administer medications as ordered by the physician. She explained if a medication was not available, a nurse should never administer an alternative dose without consulting the physician. The facility's policy titled Administering Medications revised April 2019 indicated that medications were to be administered in a safe and timely manner, and administered in accordance with prescribed orders.		