

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Aviata at Lakeside Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 1061 Virginia St Dunedin, FL 34698	

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a safe and orderly discharge for one residents (#1) and failed to follow up post discharge for two residents (#1 and #10) out of three residents sampled. Findings included: 1. Review of Resident #1's admission record showed he was admitted on [DATE] and discharged on 6/20/25 to Private home/apt. (apartment) with no home health services: Home. Resident #1's medical diagnoses including the following: Stage 3 pressure ulcer of sacral region, paraplegia, chronic pain and osteomyelitis of the spine. Review of Resident #1's physician order dated 6/20/25 revealed Resident to discharge 6/20/25, DME [durable medical equipment]: 18 in (inch) W/C (wheelchair) with leg rests; shower chair, bedside commode; hospital bed; slide board; recliner chair; large briefs; wound care; physical therapy/ occupational therapy eval (evaluation) and treat (treatment). Review of Resident #1's physician order summary report, showed orders including: An order dated 6/19/25 revealed, discharge on [DATE], send all non-controlled medications. Send three days of narcotics. Order dated 6/11/25, apply zinc [ointment] to left ischium daily and as needed. Order dated 6/1/25, Cleanse left ischium wound with Dakins sol 0.125%, apply collagen powder, Cal Alginate and cover with superabsorbent dressing daily and as needed. Order dated 4/11/25, Oxycodone 15mg every 4 hours as needed for non-acute pain. Review of Resident #1's Medication Administration Record (MAR) dated 6/1/25-6/30/25 showed Oxycodone 15mg every 4 hours as needed for non-acute pain was given 43 out of 56 opportunities, between five to six dosages daily. Review of Resident #1's wound care provider note, dated 6/18/25 showed the reason for the visit was a stage four sacral pressure ulcer follow-up. Treatment clean wound with Dakins solution 0.125%, cover with collagen, alginate, super absorbent and bordered dressing daily. Recommendations include off load wound, turn and reposition per facility policy. Review of Resident #1's pain management provider note, dated 6/19/25 showed current regimen is reported reasonable effective to maintain comfort and motivation with person Activities of Daily Living [ADL's] . Plan he had dc [discharge] plans in place; .will ok 3 days of opiates to go home with patient .he is concerned in regard to quantity of PRN meds; oxycodone 15 mg every 4 hours; have discussed with nursing/ADON. Review of Resident #1's Minimum Data Set (MDS), dated [DATE], Section C, cognitive patterns revealed a Brief Interview for Mental Status (BIMS) summary score of 15 out of 15 indicating intact cognition. Section GG, Functional Abilities showed Resident #1 had impairments to bilateral lower extremities, uses a manual wheelchair for mobility, requires substantial to maximal assistance to get in and out of a tub or shower and needs full assistance with shower/bathe. Resident #1 requires partial to moderate assistance when positioned from sitting on the side of the bed to lying down, transferring from a bed to a chair and getting on and off the commode. Review of Resident #1's Social Service Progress notes showed the following: A note dated 6/16/25, Resident said he would like to be discharged from the current facility by 6/20/25. Social Service staff faxed a request for DME and Home Health (HH) and will request the resident's discharge address prior to facility discharge. A note dated 6/17/25 showed the facility called Resident #1's home care service provider and told the name of the home health provider and was informed DME had not been established with a vendor. The facility's social service staff will follow up with the home care service provider to see when a DME provider is chosen. A note created on 6/20/25, dated 6/19/25 showed, call placed to the home care service provider to inquire about the DME for Resident #1's 18 (inch) W/C (wheelchair). The home care provider services representative has not received insurance authorization. A note dated 6/20/25, Social Service staff was contacted that authorization for wheelchair had not been obtained and a request for the facility's social services to reach out to Resident #1's insurance to find out when authorization and be established. A review of Resident #1 Primary Care Physician (PCP) note dated 6/17/25 showed continue oxycodone for pain, on Naloxone (antidote) as directed . continue wound care management for pressure ulcers, .fall precautions and use of safety devices A review of Resident #1's discharge plans and instructions, with an effective date of 6/18/25, showed the following: The name of who will accompany Resident #1 was not listed. The disposition was home by car. Part 2; Physician information: Section E- Home Health Services: Receiving Home Health Services is not marked, Section F- Medical Equipment Supplier: receiving medical equipment is not marked and Section K- Wound Care: Receiving Wound Care Services is not marked. Part 4- Functional Status Evaluation discharge: Section 3- shows Resident #1 usually needs setup or clean up assistance before and after voiding or having a bowel movement The helper does all the task when transferring from a bed to a chair. The ability to transfer in and</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure treatment and care were provided after an upper extremity fracture in accordance with professional standards of practice for one resident (#2) of three sampled residents. Findings included: On 8/27/25 at 10:05 a.m., Resident #2 was observed sitting up in bed wearing a hospital gown. Resident #2's left arm was observed to be without movement and laid straight at his side. He was not wearing a left arm sling. Review of Resident #2's medical record revealed he was readmitted to the facility on [DATE] with diagnoses to include: cerebral infarction due to thrombosis of right middle cerebral artery; muscle weakness (generalized); spastic hemiplegia affecting left nondominant side; other symptoms and signs involving cognitive functions and awareness; aphasia following cerebral infarction; other schizoaffective disorders and was updated to include unspecified fracture of upper end of left humerus on 7/23/25. Review of Resident #2's medical record showed he had a designated healthcare proxy. On 8/21/2025 Resident #2 had a Brief Interview for Mental Status (BIMS) score, of 15 indicating intact cognition. Review of Resident #2's Emergency Department (ED) Discharge (DC) instructions from an acute care facility dated 7/22/25 at 5:24 p.m. shows: See Orthopedic surgery within 3-5 days. Please call to arrange an appointment for your left humerus fracture. Review of Resident #2's facility orders on 7/23/25 showed: sling to left arm as allowed and tolerated every shift related to unspecified fracture of upper end of left humerus, subsequent encounter for fracture with routine healing. There were no orders found for orthopedic surgery follow-up. Review of Resident #2's Treatment Administration Record (TAR) shows sling to left arm as allowed and tolerated every shift was checked off as performed for 8 of 9 days in July and 26 of 27 days in August. Review of Resident #2's progress notes dated 7/24/25 and 8/6/25 by the Resident's Primary Care Physician (PCP) stated: Plan includes: left arm sling, continue to monitor. Physician Progress notes dated 8/14/25 8:17 p.m. by the Resident's Nurse Practitioner stated: Left humerus fracture: continue immobilization and orthopedic follow-up per protocol. There were no progress notes stating the resident refused the left arm sling. Review of Resident #2's care plan initiated on 9/9/24 and revised on 5/15/25 shows: Alteration in usual functional performance in self-care related to CVA, use of psychoactive medication, communication impairment with a goal that stated the resident's functional performance in self-care will maintain at current functioning level through the next review target date of 11/26/25. The most recent intervention included: Apply sling to left arm as allowed and tolerated (initiated 7/23/25). There were no other interventions initiated since 7/23/25 including in other focus areas of the care plan. An interview was conducted with Resident #2 on 8/27/25 at 11:15 a.m. Resident #2 stated they put my arm in a sling after my injury. I don't need it anymore. My arm is better. During a phone interview on 8/27/25 at 1:24 pm with Resident #2's healthcare proxy, the healthcare proxy stated: He won't wear the sling for the left arm. The hospital ED said Resident #2 needed to see a bone doctor, but I was told by nursing at the facility that it was not recommended. During an interview on 8/27/25 at 2:00 p.m. with Staff Q, LPN, Staff Q stated if the staff makes a check mark in the TAR for an arm sling it means the sling is on. If the resident didn't have it on, I would chart 'No' and then make a note about it. Or we can use the number codes to say 'Other, refused', but I would make a note. During an interview on 8/27/25 at 2:20 p.m. with Staff P, CNA, Staff P stated I usually get Resident #2 out of bed every day. I know he used to have a left arm sling, but the resident is not wearing it anymore. The CNAs can put that on, but I haven't for a while. An interview was conducted with Staff O, RN on 8/27/25 at 2:25 p.m. Staff O said the left arm sling order is when needed (PRN). If there is a checkmark in the chart, it probably means it is on. Resident #2 hasn't been wanting to wear it. I don't even know if Resident #2 still needs it. Therapy or the doctor would make that decision. I haven't been able to discuss this with the doctor because I am only here once a week. An interview was conducted with the Medical Records Coordinator (MRC) on 8/27/25 at 4:20 p.m. The MRC said she schedules all residents' physician appointments. She says Resident #2 doesn't have any appointments coming up and hasn't had an appointment outside the building since March. A telephone interview was conducted with Resident #2's PCP on 8/28/25 at 9:50 a.m. The PCP stated treatment of this comminuted fracture often does not include surgery, but the orthopedic surgeon would make that determination. The PCP was not aware that the resident has not seen orthopedic surgery yet. The PCP said treatment with a sling is mainly for comfort, but it may continue to be used until the arm is re-X rayed. The orthopedic surgeon would need to re-Xray to determine healing even if surgery is not performed. During an interview on 8/28/25 at 2:30 p.m. with the</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review, the facility failed to maintain accurate records of controlled substances and ensure narcotics were reconciled as required for three residents (#2, #3, and #4) out of three sampled residents. Findings included: On 8/27/2025 at 10:03 a.m., an interview was conducted with Resident #3. Over a week ago the resident did not receive the prescribed oxycodone 10 mg during an evening shift. The resident stated the pain medication was due at 6:00 p.m. Staff U, Licensed Practical Nurse (LPN), was asked several times to administer the medication. The resident did not receive the medication until the next shift. Review of the Medication Administration Record (MAR) and the Medication Monitoring/Control Record, the Narc log, revealed administrations were present in the Narc log but the corresponding administrations were not documented in the MAR. The following findings detail the volume of administration not documented in the MAR: Review of the Medication Administration Record dated 7/1/2025 through 7/31/2025, revealed Resident #3's MAR was missing nine out of 56 doses of Oxycodone 10 mg recorded on the Narc log. Resident #2's MAR was missing five out of the 90 doses of Norco (hydrocodone / acetaminophen) 325 mg recorded on the Narc log. Resident #4's MAR was missing 10 out of the 62 doses of Oxycodone 10 mg recorded on the Narc log. Review of 8/1/2025 through 8/15/2025 MAR records, revealed Resident #3's MAR was missing 10 out of 31 doses of Oxycodone 10 mg recorded on the Narc log. Resident #4's MAR was missing 2 out of the 13 doses of Oxycodone 10 mg recorded on the Narc log. On 8/28/2025 at 9:25 a.m., an interview was conducted with Resident #4. The resident began to use pain medications when physical therapy started. Resident #4 said medication is required to improve the residents' pain tolerance during the physical therapy sessions. The pain medication is scheduled for every 4 hours now. The resident will request the medication before physical therapy and would like it to be coordinated with physical therapy more often. On 8/28/2025 at 10:11 a.m., an interview was conducted with Staff H, LPN. She described the facility's process for receiving and documenting controlled substances. The pharmacy brings the medications to the facility, and two nurses must sign to receive the medications. They record the medication information in the Narc book. She stated when the medications are scheduled then they are administered during that scheduled time. If the medication is PRN, as needed, then it is administered if the resident asks for it. The medications are supposed to be recorded in the MAR and on the narcotic count sheet. She revealed that if you forget to record a medication, then the medication can be back dated. She was unsure of a certain amount of time allowed to back date a medication, but she knows that documentation should be done immediately. She stated that if the narcotic count does not match the documentation, then they are required to flag it. They must then let the Director of Nursing (DON) or the Assistant Director of Nursing (ADON) know about the error. She has received some training on the facility's controlled substance reconciliation policy. She was unsure about the date the training occurred. Her most recent training was in June 2025 regarding the facility's two-nurse system. The narcotics are stored in the medication carts, with a two-lock system. She has never encountered a narcotic discrepancy. During shift-to-shift narcotic count verification, the nurses look at the number of medications on the Narc Sheet and count it all together. If medication is not available in the cart, then the nurse must retrieve the medication from a medication dispensing system. They must call the Pharmacy Consultant and are given a code to retrieve the medication out of the medication dispensing system. A pharmacy representative performs monthly checks of the medication dispensing system. On 8/28/2025 at 10:23 a.m., an interview was conducted with the Director of Nursing (DON). The DON said the narcotic medications come from the pharmacy with a manifest slip. Two nurses are required to sign for the medications and log them into the Narc book. The medications are placed in the locked medication cart and counted every shift. Narcotics are reviewed at the management level at least every week. An audit is performed 10 times a month. If a discrepancy is reported, then he will try to figure out how it happened. If there was a diversion found, then one of the regional supervisors would be involved in the investigation. The DON revealed that there have not been any investigations into narcotic discrepancies in the last six months. He also has never reported narcotic discrepancies to the state board, Drug Enforcement Administration (DEA), or law enforcement. He related that training is completed during the narcotic auditing and during employee onboarding training. Discontinued medications are placed in a two-drawer locked file cabinet until destruction. Destruction of narcotics is completed with the Pharmacy Consultant during the monthly review. On 8/28/2025 at 10:35 a.m., an interview was conducted with the Pharmacy Consultant. He stated that he monitors the controlled substances in this facility. He tracks what is coming into the facility, checks the logs</p>		