STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105413	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Brooksville	1445 Howell Ave Brooksville, FL 34601

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 prevent the possible spread of infection for not maintaining infection prevention and control practices in the management of intravenous catheters for 1 of 3 residents, Resident 3, reviewed for IV (intravenous) therapy.Findings include: During an observation on 6/25/2025 at 9:40 AM, Resident #3's PICC (peripherally inserted central catheter) line on his right upper arm had a dressing that was dated 6/22/25. The dressing was comprised of a transparent semi-permeable membrane, with pieces of square gauze pads directly over the insertion site preventing observation of the site. During an observation on 6/25/2025 at 12:07 PM, Staff A, Licensed Practical Nurse (LPN), flushed Resident #3's PICC line with normal saline solution and disconnected the syringe, leaving the end of the connection exposed. Resident #3 was observed resting his upper right arm; with the connection against his body. Staff A prepared the IV antibiotic medication and attached the IV tubing to the distal end of the PICC line connection, without wiping the connection prior to attaching the IV tubing. During an interview on 6/25/2025 at approximately 12:15 PM, Staff A, LPN stated, I should have wiped the tip of Resident #3's PICC line with the alcohol wipe before I connected the IV tubing for the antibiotics. During an interview on 6/25/2025 at 1:30 PM, the Assistant Director of Nursing stated, The expectation for central line care is that the nurses would scrub the hub [the practice of disinfecting the connection point (hub) of an intravenous (IV) catheter or needleless connector before accessing it with a syringe or other device. This technique is crucial for preventing infections, by reducing the risk of introducing bacteria or other pathogens into the bloodstream] before connecting a syringe or IV tubing to the catheter. Review of the facility policy and procedures titled Catheter Insertion and Care - Central Venous Catheter Dressing Changes with an effective date of 1/17/2019 read, Policy: Central venous catheter dressings will be changed at specific intervals, or when needed, to prevent catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings . General Guidelines . 5. If gauze is used, it must be changed every 2 days . 7. Catheter site care and dressing changes will include . b. Observation and evaluation of the catheter - skin junction and surrounding tissue.

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