STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105440	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Colonial Lakes	15204 W Colonial Dr Winter Garden, FL 34787

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents' right to privacy for 2 of 2 residents reviewed for privacy, out of a total sample of 52, (#90 and #159).Findings: 1. Resident #90 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure, weakness, anxiety and diabetes. Review of the Minimum Data Set (MDS) quarterly assessment with assessment reference date (ARD) of 2/9/26 revealed resident #90 had a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated she was cognitively intact. Resident #90 had impairment to one side of her upper extremities and required substantial/maximal assistance for personal hygiene. On 3/31/26 at 9:18 AM, resident #90 was observed in her bed with the head of bed elevated. She stated the middle curtain which divides the space between the A and B beds in the room was too narrow and did not provide privacy during care. The curtain was noted to be fully extended with spaces on either side which exposed the head and foot of the bed. On 4/01/26 at 11:30 AM, the curtain between A and B beds in resident #90's room was noted to be extended with spaces on either side which exposed the head and the foot of the bed. On 4/02/26 at 9:45 AM, the Certified Nursing Assistant (CNA) C stated she was assigned to resident #90. She observed the middle curtain in the room and confirmed the curtain was too narrow to provide privacy during care. She stated she tried to provide as much privacy as she could given the size of the curtain. CNA C explained that housekeeping was responsible for changing the curtains in the resident rooms. 2. Resident #159 was admitted to the facility on [DATE] with diagnoses including dementia, spinal cord injury, anxiety, hypertension, kidney failure and depression. Review of the MDS quarterly assessment with ARD of 2/02/26 revealed resident #159 had a BIMS score of 3/15 which indicated he had severe cognitive impairment. The assessment indicated he had impairments on the upper and lower extremities on both sides of his body and was dependent on staff for care including personal hygiene. On 3/30/26 at 12:40 PM, resident #159 was observed in the bed closest to the window, lying on his back. The curtain between the two beds consisted of two curtains which were opened in the middle exposing resident #159 to people outside the room. On 4/01/26 at 9:30 AM, resident #159 was in bed on his left side facing the door. The air conditioner next to the bed was on and the divider curtains were noted to be moving and had separated exposing resident #159's mid-section to anyone passing by the open door. On 4/02/26 at 10:03 AM, the Environmental Services Manager stated he is responsible for changing the curtains in residents' rooms. He observed the privacy curtain in resident #90's room and confirmed there was only one curtain. The Environmental Services Manager measured the curtain and reported it was 64 inches in width. He acknowledged the privacy curtain was not wide enough to provide complete privacy as the bed was 96 inches long. He explained the additional curtain had been taken to laundry. The Environmental Services Manager acknowledged a replacement curtain should have been hung when the other curtain was removed. He walked across the hall to resident #159's room and noted the curtains were separated in the middle. He examined the curtains and explained they were not hung appropriately to ensure enough of an overlap to provide privacy to the residents when extended. On 4/02/26 at 10:21 AM, the Nursing Home Administrator (NHA) expressed his expectation was for each residents' privacy to be respected. He stated he was informed of the issues related to the width of (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the privacy curtains and acknowledged they should be wide enough to provide privacy during care. Review of the facility's policy and procedure for privacy effective 11/30/14 indicated the company's policy was to give all residents the opportunity for privacy and each resident's privacy would always be respected.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations interviews and record review, the facility failed to administer medication as ordered by the physician for 1 out of 3 residents sampled for pain management of a total sample of 52 (#104). Findings:Resident #104 was admitted to the facility on [DATE] with diagnoses that included quadriplegia, muscle weakness, muscle spasm chronic pain due to trauma and unspecified injury at unspecified level of cervical spinal cord.Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed resident #104 was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. The MDS also revealed the resident had pain that interfered with sleep occasionally.On 3/30/26 at 12:13 PM resident #104 was lying in bed and stated that his pain was not controlled. He said that the medication he received doesn't seem to relieve his pain and he had told facility staff of his concern.A review of the March 2026 Medication Administration Record (MAR) revealed orders for Dantrium oral capsule 25 mg (Dantrolene Sodium) 1 capsule to be given by mouth at 6 AM, 2 PM and 10 PM for muscle spasms. This medication was discontinued on 3/31/26. The MAR revealed the resident received Dantrium on the following dates and times:3/2/26 at 2 PM (missed 2 doses 6 AM and 10 PM)3/23/26 at 2 PM (missed 2 doses 6 AM and 10 PM)3/24/26 at 2 PM (missed 2 doses 6 AM and 10 PM)3/26/26 at 2 PM (missed 2 doses 6 AM and 10 PM)3/27/26 at 6 AM and 10 PM (missed 2PM dose)3/28/26 at 6 AM and 2 PM (missed 10 PM dose)3/29/26 at 2 PM (missed 2 doses 6 AM and 10 PM)3/30/26 at 2 PM (missed 2 doses 6 AM and 10 PM)3/31 at 6 AMReview of nurse's progress notes regarding the missed doses of Dantrium read; on 3/23/26, 3/26/26 and 3/27/26 medication on order, on 3/28/30, 3/30/26 and 3/31/26 progress notes read medication not available until next week per pharmacy.On 4/01/26 at 3:56 PM, the Pharmacy Technician stated that the medication was last delivered on 3/13/26 and 3/7/16. The Pharmacy Technician said that there was a scheduled delivery today for a 5-day supply of the medication and at no time should a medication run out before reorder dates.A review of the MAR showed Licensed Practical Nurse (LPN) E signed that she administered the medication on 3/25/26 at 2 PM but did not administer it on 3/28/26 at 2 PM.On 4/02/26 at 10:55 AM, LPN E opened the medication cart and retrieved two blister packs of the medication with a label that showed 90 capsules were delivered on 3/5/26 with a reorder date of 3/31/26. There were at least 13 capsules remaining. There was also a brand-new blister pack of the medication with a total of 15 capsules delivered on 4/01/26. LPN E explained that she was removing the medication from the cart because she believed it was discontinued. LPN E said that she was familiar with resident #104 and did not have any issues with reordering medications. LPN E explained that she administered the medication as ordered and if she signed that it was not administered, then it was not on the cart. She continued to explain that she would have followed up with the pharmacy and called the physician.On 4/02/26 at 12:05 PM, the Director of Nursing (DON) reviewed the MAR with corresponding progress notes for March 2026 and could not explain why some nurses documented that the medication was on order from pharmacy whereas, other nurses were able to administer the medication on the same day. She said she would follow up with the nurses to find out what happened.A review of the MAR showed LPN D signed that Dantrium was not administered 5 out of the 8 doses not administered at 2 PM.On 4/02/26 at 1:20 PM, LPN D explained that she would never sign that a medication was administered if she did not have it. She acknowledged all the times she documented the medication was not administered. She also acknowledged her progress note written on 3/26/ 26 that the medication was on order because it was not on the cart. LPN D remembered that she called the pharmacy last week and was told that it was too early to be refilled and that she should have had enough coverage. LPN D explained that she did not find any in the medication cart nor accessed the pyxis and she did not follow up with pharmacy nor anyone else after.On 4/02/26 at 1:45 PM, the DON did not give any additional explanation for the missed doses and said she only spoke with LPN D and could not reach the other nurses who signed that the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication was not available. The DON said, clearly the medication was in the cart and maybe they did not look for it. She explained that her expectation is that nurses follow the physician's orders and look for the med.The facility's policy on Administering Medications revised April 2019 stated medications are administered in a safe and timely manner and as prescribed and the Director of Nursing Services supervises and directs all personnel who administer medications.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure licensed nurses were knowledgeable and demonstrated competency to provide care and services per standards of care for a medication administration for 1 of 6 resident reviewed during observation of medication administration, out of a total sample of 52 residents (186). Findings:Resident #186 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus. Severe dementia, major depressive disorder, brief psychotic disorder, seizures, hypertension, dysphagia, and adult failure to thrive.On 3/31/26 at 8:37 AM, Licensed Practical Nurse (LPN) B, prepared resident #186's scheduled medications at her medication cart. She poured Colace 100 milligrams (mg), Lamotrigine 25mg, Losartan 100mg, Multi-vitamin 1 tablet, Tradjenta 5mg, Zinc 50mg and 2 tablets of Metformin 500mg. LPN B then placed the medicine into a clear sleeve and crushed the medication. LPN B then stated that she will ask 'if she wants it in her food or fluids'. LPN B took the sleeve of medications and walked down to the resident's room. When LPN B exited the resident #186's room she no longer had the medication in her hand. LPN B stated that she poured the medication over the resident's breakfast. Upon entering the resident's room, resident #186 was noted to be sitting up in bed being assisted with feeding by a Certified Nursing Assistant (CNA). The CNA was noted to be sitting to the left of the resident feeding the resident spoonful's of her breakfast. LPN B stated that she poured the medication into the resident's breakfast because the resident was a ?feeder' and it is the only way she will take her medication. Resident noted to grimace and grunt after CNA fed her a spoonful of her breakfast. LPN B stated that the resident must have received a spoonful her breakfast with some of the crushed medication and asked the CNA to give the resident a sip of her drink in order to wash down. LPN B then proceeded to leave the resident's room and return to her medication cart.On 3/31/2026 at 11:30 AM LPN B acknowledged that she poured the medication into the resident's breakfast and then left the resident's room for the CNA to administer. LPN B acknowledged that it is out of a CNA's scope of practice to administer medication. LPN B stated that she should have placed the medication in a small medicine cup with a small amount of applesauce and administered that herself. LPN B acknowledged that procedure for medication administration requires a nurse to remain with the resident while medication is being administered to ensure that the resident took the medication safely and completely. LPN B did not respond when asked what she would have done if the resident did not finish her breakfast.On 4/1/26 at 11:21 AM, the Director of Nursing (DON) verified that the facilities procedure for medication administration is for the nurse who prepared the medication to be the one who administers it. She acknowledged that in this instance the CNA was the person administering the medication which is out of scope of practice. She confirmed the CNAs at the facility are not qualified to administer medications and have received no training for medication administration. The facility does not employ Qualified Medication Aides (QMA) currently. She stated that the expectation is for nurses to stay with the resident during the entire medication administration in order to ensure the medication was administered safely and completely. The DON acknowledged that pouring medication into a resident's meal can lead to many issues including some of the medication not being administered if the resident does not complete their meal.Review of Florida Administrative Code on medication administration revealed a CNA cannot administer medication without receiving medication administration training and obtaining a validation for the route the medication is being administered. Further review of Florida Administrative Code revealed a LPN shall not delegate an activity for which the CNA has not demonstrated competence. (retrieved from https://flrules.org/gateway/ChapterHome.asp?Chapter=64B9-16 on 4/10/26)Review of the Job Description for Clinical Nurse I (LPN) revealed a LPN must act in accordance with company and regulatory and professional standards and guidelines.Review of facility policy titled Administering (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medications revised April 2019 revealed that only a license or permitted by this state is to prepare administer and document the administration of medications may do so.

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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 observation, interview, and record review, the facility failed to maintain accurate and complete medical records for 1 of 2 residents reviewed for mood and behavior, of a total sample 52 residents, (#31).Findings:Resident #31 was admitted to the facility on [DATE] with diagnosis including hemiplegia and hemiparesis following a cerebral infarction, autistic disorder, pseudobulbar affect, gender identity disorder, major depressive disorder, mild cognitive impairment, mild neurocognitive disorder due to know physiological condition with behavioral disturbance, mood disorder, anxiety disorder and noncompliance with medical treatment and regimen due to unspecified reason. A review of the resident's care plan revealed resident #31 identified as transgender and prefers she/her pronouns. Resident #31 had a care plan for behaviors related to refusing medications, refusing care, crawling on the floor, cursing out staff, accusatory behaviors such as claiming staff stealing her items and attention seeking behaviors. The resident was noted to have another behavior care plan which noted resident #31 had a behavior of physical aggression such as throwing things on the floor and at her television. She was also noted to at times be verbally abusive toward staff. Resident #31 had a care plan with the focus for a communication problem related to the resident rarely speaking and communicating by typing on phone at times. A psychology consult from 3/26/26 revealed that resident #31 was having ongoing mood lability with increasing agitation and behavioral dysregulation. The resident recently had medication adjustments which were in progress and required time to reach therapeutic effect. The plan of care included to continue current psychotropic medication regimen as well as allow time for medications to reach therapeutic effect before further adjustments. The staff were to report any worsening behaviors, safety concerns, or need for as needed or emergency interventions.A review of the resident's physician orders revealed an order for haloperidol lactate injection 5 milligrams per milligrams (mg/ml) for 5mg to be injected intramuscularly (IM) one time for agitation with a start date of 3/23/26. Review of the electronic medication administration record (EMAR) revealed the medication was administered on 3/23/26 at 12:13 PM.Resident #31's progress note on 3/23/26 at 10:43 AM, revealed that the resident had been exhibiting increased agitation since the previous night. The resident had demonstrated aggressive behaviors, including hitting staff members and throwing objects. Verbal redirection and de-escalation techniques were attempted but were ineffective in managing the behavior. The provider was notified of the patient's condition. Following assessment and consultation, a one-time order for haloperidol lactate 5 mg intramuscular injection was received and carried out as prescribed.Haloperidol is classified as an atypical antipsychotic which can be used to treat a variety of symptoms in autism and mood disorders. It can be used to treat irritability and associated behaviors including aggression and self injury (retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC2171144/#:~:text=Subjects%20were%20assigned%20to%20cycles,t on 4/2/26).A review of the resident's physician orders revealed an order for haloperidol oral tablet 2mg to be injected intramuscularly one time for agitation with a start date of 3/25/26. Review of the electronic medication administration record (EMAR) revealed the medication was administered on 3/25/26 at 1:17 AM.Review of the resident's progress notes revealed no documentation at the time the haloperidol was administered as to the rationale for the need of the medication.A review of the resident's physician orders revealed an order for haloperidol lactate Injection for 2mg to be injected intramuscularly one time for agitation with a start date of 3/26/26. Review of the electronic medication administration record (EMAR) revealed the medication was administered on 3/29/26 at 11:05 PM.Review of the resident's progress notes revealed no documentation of the behaviors that required the haloperidol as the intervention.Review of the resident's progress notes revealed no documentation at the time the haloperidol was administered as to the rationale for the need of the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication.On 4/2/26 at 8:31 AM, the Pharmacy Technician revealed in the month of March only two doses of haloperidol injection were filled by the pharmacy. One dose was sent on 3/23/26 and one dose was sent on 3/26/26. No dose was sent from the pharmacy on 3/25/26. On 4/2/26 at 11:13 AM, phone interview with RN F revealed that on 3/25/26 resident #31 had become aggressive and yelling. The resident had punched her. She stated she had called the physician for an order for IM haloperidol. She stated that she did not pull the medication for the emergency medication kit. She replied that the resident had a box of haloperidol IM in the medication cart and that is what she used. She could not remember the dose but confirmed she did not give the medication orally.On 4/2/26 at 11:40 AM, the Director of Nursing (DON) stated that an order written for a 2mg tablet of haloperidol to be given intramuscularly would need clarification before administration. She was unable to answer how the medication was given if the pharmacy did not supply it and the emergency medication kit did not stock 2mg haloperidol. She stated that the expectation for nurses is to document any changes with the residents which includes behaviors and new orders from the physician. Her expectation was for nurses to document behaviors that led up to the administration of haloperidol as well as all interventions that were used prior to the administration.Review of facility policy titled Administering Medications revised April 2019 revealed that the individual administering the medication should document any complaints or symptoms for which the drug was administered in the resident's medical record.