

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: 105452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER Aviata at Englewood		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Drury LN Englewood, FL 34224	
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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, medical record reviews and a facility policy review, the facility failed to protect the resident's right to be free from neglect by leaving the resident unattended during incontinent care and not adequately training staff in resident care, thereby allowing the resident to fall off the bed which resulted in a serious injury for 1 Resident, (Resident #1), of 3 residents reviewed for neglect. The findings included: Review of the facility's policy for Abuse, Neglect, Exploitation and Misappropriation effective 11/30/2014 and last revised 11/16/2022 stated, It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property . Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include failure to take precautionary measures to protect the health and safety of the residents. It was reported on November 12, 2025, that Resident #1 was receiving incontinent care by Staff A, CNA (Certified Nursing Assistant). Staff A, CNA admitted to leaving Resident #1's bedside to dispose of brief and to get towels. Staff A, CNA left Resident #1 lying on her side on the edge of the bed unattended. Resident #1 fell off the bed and obtained a laceration to her head and subdural hematoma (bleeding in the brain) requiring a higher level of care. Medical record review revealed Resident #1 was admitted to the facility on [DATE] with diagnosis including Heart Failure, Atrial Fibrillation, Repeated Falls, Hypothyroidism, Obesity, Hypertension, Aortic Stenosis with insufficiency, Mood disorder, cardiac pacemaker, and Dementia. The Brief Interview for Mental Status (BIMS) Assessment completed on 8/22/2025 revealed a score of 5/15 which indicates severely impaired cognition. The Care Plan Report provided by the facility in effect during the time of Resident #1's fall revealed a requirement that included rolling resident from side to side, side to back, and dependent with 1-2 staff assist. Record review for Resident #1 showed a Nursing Progress Note dated 11/12/2025 at 10:35 a.m., which stated, CNA notified this nurse that resident is on the floor. Upon entry, resident is laying on the floor between bed A&B. A pool of blood observed by resident's head Resident #1 was transferred to hospital via EMS at approximately 10:30 a.m. The facility conducted an investigation of Resident #1's fall. The investigation included a witness statement given by Staff A, CNA which read, I was cleaning up Resident #1 and as I threw away her soiled diapers I went to search for a towel in one of the cabinets. She was on her side the whole time. I didn't have any problems cleaning her before, so I assumed she was OK. She then immediately said she was sliding off the bed. I turned around to help her, but I couldn't reach her in time, and she slid off the bed and fell down. I immediately grabbed the nurse, and I started to help with towels. On 11/24/2025 at 1:06 p.m., during a telephone interview with Staff A, CNA said he was cleaning Resident #1 when he turned away for just a second to throw away her brief and she fell out of bed. He said that he didn't know her very well and was not aware that she required a one to two person staff assist with turning and repositioning. He said before she fell, he hadn't been trained to look up how to find specific information about residents in the Kardex (Computer program accessible by CNA's to access patient (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	information).On 11/24/2025 at 12:30 p.m., during an interview the APRN (Advanced Practice Nurse Practitioner), said he was not present when Resident #1 fell out of bed, but the nurse immediately came and got him. When he saw the resident, she was lying on her back and bleeding from her head. He said Staff A, CNA, was providing care when the resident rolled out of bed. The resident was on blood thinners, so they transferred her out immediately to a higher level of care. She was in the hospital for a couple of days and then returned to the facility. She had a diagnosis of non-surgical subdural hematoma.On 11/24/2025 at 3:48 p.m., the Director of Nursing (DON) said that Staff A, CNA, was performing incontinent care when he went to dispose of a brief and wash his hands. She said Staff A, CNA left the patient laying on her side on the edge of the bed and staff are supposed to ensure residents are in safe position prior to leaving bedside. The Resident was not left in a safe position and this is when Resident #1 fell out of bed. The DON could not verify that Staff A, CNA, had received training for the Kardex prior to Resident #1's fall. She said, I did the training after the fall.On 11/24/2025 at 3:55 p.m., the facility Administrator said he was aware that Resident #1 had received an injury during care but the staff member followed the residents care plan.		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, and staff interviews, the facility failed to provide adequate supervision to prevent falls with major injury for 1 (Resident #5) of 3 residents reviewed for falls. The findings included: Facility policy titled Falls Management Revision Date 7/29/2019 indicated: Fall mitigation strategies included developing resident centered interventions based on resident risk factors. Record Review of the facility provided incident log revealed Resident #5 had 5 falls between 12/14/25 and 1/6/26. Review of Resident #5's progress notes reveal on 12/14/25 resident was found on the floor and assisted back to bed with no change in condition noted at that time. On 12/16/25 resident was noted in nursing progress note to have inverted left lower extremity and shortening of the left lower extremity. An order was obtained to send Resident #5 out to the emergency room (ER). Resident returned from the ER the same day with a diagnosis of pubis ramus fracture. Nursing progress note on 12/20/25 indicated Resident #5 was found on the floor, half in and half out, of his bathroom. Head to toe assessment revealed no injuries. Nursing progress note on 12/25/25 indicated Resident #5 had an unwitnessed fall and hit his head. No other injuries and no complaint of pain. Order received to send to ER due to being on blood thinner medication. Resident #5 returned from the ER later that same day with no new orders. Nursing progress note on 12/27/25 indicated Resident #5 had an unwitnessed fall and was found lying on his right side on the floor in his room. Resident said he stood up to straighten his bedside table, lost balance and slid down to floor. No injuries at that time. Nursing progress note on 1/6/26 indicate Resident #5 was found sitting on floor in front of his door. Resident said he was trying to close door and ended up sliding down to the floor. Resident #5 sustained a small skin tear to his left knee. Provider's progress note on 1/7/26 indicated Resident #5 had complaints of hip and groin pain. A stat x-ray was ordered and revealed a complete fracture of the left femoral neck with superior lateral displacement. Additionally, a pubis ramus fracture was identified on the imaging. Due to the displacement and complete fracture an order was placed to transfer to the ER. Nursing progress note on 1/10/26 indicated resident was readmitted to the skilled nursing facility following left hip surgery with 38 staples in place. Provider progress note on 1/13/26 indicated Resident #5 had returned to the facility on 1/10/26 following a left hip repair secondary to a mechanical fall. Resident #5's orders included: physical therapy, fall mats, low bed when in bed, and scoop mattress. Certified Nurse Assistant (CNA) Kardex indicated under safety to ensure resident is wearing appropriate footwear/nonskid socks when ambulating or mobilizing in wheelchair and ensure the resident has unobstructed path to the bathroom. Kardex also indicated under bed mobility: bed in low position. Resident #5's care plan addresses fall risk with interventions including bed in low position, appropriate footwear, physical therapy, fall mats, frequent checks every 15 minutes, hand bell to assist with calling staff, offer toileting every 2 hours. On 1/14/26 at 2:59 p.m., Staff F (CNA) said she was taking care of Resident #5. She said she watches for falls and checks on him every 2 hours, but that was not documented anywhere. She said he was a fall risk, and his bed was kept low. On 1/14/26 at 3:01 p.m., Staff G (CNA) said he has worked with Resident #5, and he was an assist to the restroom. Staff G said earlier that day he found Resident #5 standing at the side of his bed. Staff G said Resident #5 hadn't fallen, but he gets on the side of the bed sometimes, he did his own thing. Staff G said Resident #5 hadn't been incontinent. Staff G said he had seen him in bed when he passed his lunch tray and when he went back in to pick it up was when he found him standing at the side of the bed. On 1/14/25 at 1:56 p.m., the Physical Therapist (PT) said they began working with Resident #5 when he came back from the 12/14/25 pelvic fracture. PT said she doesn't think Resident #5 remembers he can't get up by himself anymore. She said he needed assistance, but he tries to get up by himself and doesn't call for help. She said they have tried to educate him as much as possible, did the low bed, added fall mats and several other interventions, but he had a habit of doing what he wanted to do. Saying Resident #5 was very independent minded. PT said they continue to work with (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	him, both Occupational and Physical therapy, trying to reinforce safety awareness. On 1/14/26 at 1:25 p.m., the Director of Nursing (DON) said she was aware of Resident #5's multiple falls. She said all his falls have been unwitnessed and they have placed gripper socks, 15-minute checks, 2-hour toileting, fall mats, scoop mattress, bed in low position, a hand bell to ring, but he gets up and walks on his own. The DON said Resident #5 had dementia, poor safety awareness, was forgetful, had confusion, and was non-compliant. On 1/14/26 at 3:30 p.m., the Administrator said, I don't know what you want us to do, we can't tie him down.		