STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105452	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Englewood	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure staff followed safety precautions to prevent avoidable accidents or potential for accidents for 3 (Residents #892, #66 and #442) of 3 residents reviewed.The findings included:1. Review of Notification of Change in Condition Policies and Procedures effective date 11/30/2014, revision date 12/16/2022 states the Center to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is change in the status or condition. The nurse to notify the attending physician and Resident Representative when there is a(n) accidents, significant change in the patient/resident's physical, mental, or psychosocial status. Need to alter treatment significantly: new treatment, adverse consequences, acute condition, or exacerbation of a chronic condition. The nurse to complete an evaluation of the Patient/Resident. Document evaluation in the medical record. Document resident/patient change in condition on 24-hour report. Complete SBAR as indicated.Review of Skin Evaluation Policies and Procedures effective date 11/30/201, revision date 4/1/2017 states a licensed nurse will complete a total body evaluation on each resident weekly, paying particular attention to any skin tears, bruises, stasis ulcers, rashes, pressure injury, lesions, abrasions, reddened areas and skin problems. A licenses nurse will complete a total body evaluation on each resident weekly and document the observation on the Skin Evaluation form. The evaluating nurse must date and sign each review. If a resident is assessed as having a skin problem, the evaluating nurse will initiate the appropriate form. For pressure areas, complete the Pressure Injury Record. For all other skin conditions, complete the Non-pressure Skin Condition Record.1. Review of medical record revealed Resident #892 was admitted to the facility on [DATE] with diagnosis including acute osteomyelitis (bone infections) left ankle and foot, cellulitis (bacterial infections), Peripheral Vascular Disease (reduced blood flow to arms and legs), Non-pressure chronic ulcer of skin of other sites (open sore) with necrosis (dead or dying tissue) of the bone.The admission Minimum Data Set (MDS) Assessment with a target date of 6/5/25 revealed a Brief Interview for Mental Status (BIMS) Resident #892 scored a 15 indicating intact cognition. Review of the Section for Skin Condition revealed there was no burn on admission. On 6/23/25 at 9:00 a.m., observed Resident #892 with tan bandage to right inner thigh. 6/22 was written in black felt marker on the bandage edge. The resident said he spilled the hot coffee the facility served him and he got the burn. The resident said it happened about a week ago and the facility knew about it. Resident stated the facility placed the 6/22 bandage over the burn. (photographic evidence obtained)On 6/24/25 at 9:07 a.m., observed Resident # 892 with new, undated bandage to right inner thigh. (photographic evidence obtained)Review of Treatment Administration Record (TAR) revealed weekly skin sweeps every day shift every Sunday dated 6/1/25. Treatment administration record 6/22/25 was signed by Registered Nurse (RN) Staff B.Review of Weekly Skin Integrity by the facility revealed 6/1/25 open areas to left lower extremity, treatment in place; 6/10/25 left lower leg venous ulcer being treated/followed by wound care; 6/15/25 left lower leg venous ulcer being treated followed by wound care/treatment in place; There was no weekly skin integrity completed for 6/22/25.On 6/24/25 at 04:02 p.m., Registered Nurse (RN) Staff B said she heard about Resident #892 spilling his coffee on his leg. Staff B stated, It looks like a burn. She said she did not place a bandage over it and she did not document on it. Staff B checked the resident's orders and said there was no order to place a bandage on the right thigh or any treatment order for the burn. Staff B said with an injury like a burn you need to call the doctor, document a change in condition assessment, notify the next of kin, and write an order for any treatment. On 6/24/25 at 4:15 p.m., in an interview with the Assistant Director of Nursing (ADON) RN, she said she did not know about the burn the resident got at the facility. On 6/24/25 at 4:21 p.m., in an interview with Staff E, RN, Unit Manager (UM) said she did not know about the burn to Resident # 892's right inner thigh. She said she did not know who placed the bandage on the burn. She said someone should have notified the physician, obtained an order, completed a change in condition, and initiated an incident report. Staff E, RN UM said there should always be a treatment order to apply a bandage.On 6/24/25 at 5:07 p.m., the Director of Nursing (DON) said it was very concerning there was no order, no treatment, and it was not reported. She stated, No nothing. She said the burn should have been reported. She stated, You can tell it's a burn, it's a good size.On 6/25/25 at 12:12 p.m., observed a wound to Resident #892's right inner/upper thigh. The wound was approximately 2.5 inches in length by 2 inches in width. The top layer of skin had peeled away revealing bright pink flesh. (photographic evidence obtained). On 6/25/25 at 3:22 p.m., in an interview with the DON and the Regional

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Fall Management policy and procedure, dated 11/30/2014, with a revision date of 7/29/2019, stated in the overview: A fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as the result of an overwhelming external force . Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred .Post Fall Strategies: 1. Resident will be evaluated and post fall care provided. 2. Initiate neurological checks as per policy or directed by physician order. 3. Notify the physician and resident representative. 4. Re-evaluate fall risk utilizing the Post Fall Evaluation. 5. Update Care plan and Nurse Aide Kardex with intervention(s). 6. Initiate post fall documentation every shift for 72 hours. Review of the facility's incident log revealed on 6/9/25 the facility conducted a fall investigation for Resident #442. Review of the facility's investigation related to Resident #442's fall revealed on 6/7/25 around 3:00 a.m., Resident #442's roommate was awakened by Resident #442 falling out of his bed and hitting the floor. Resident #442's roommate called for help, and a female Certified Nursing Assistant (CNA) came to the room, saw Resident #442 on the floor and went to get Resident #442's nurse, Licensed Practical Nurse (LPN) Staff A. The investigation noted: LPN Staff A came to the room a couple of minutes later with a male CNA. LPN Staff A asked Resident #442 several questions and put Resident #442 back into his bed. Staff A did not document in Resident #442's medical record that he was found on the floor on 6/7/25 around 3:00 a.m. LPN Staff A did not assess Resident #442 prior to placing the resident back in bed, did not initiate neurological checks as per facility policy, did not complete a Post Fall Evaluation form, and did not notify Resident #442's primary care physician (PCP) and resident representative. LPN Staff A LPN did not inform Registered Nurse (RN) Staff B that Resident #442 was found on the floor around 3:00 a.m. that morning as required during the morning shift change report. RN Staff B entered Resident #442's room around 12:30 p.m. The resident stated that he was nauseous and had a headache. Resident #442's roommate informed RN Staff B that Resident #442's headache could be related to the fall he had that morning. Resident #442 verified he sustained a fall that morning. RN Staff B notified the Advanced Practice Registered Nurse of Resident #442's fall and complaint of nausea and headache. The APRN Said she was not notified of the fall and would be at the facility within 45 minutes to assess the resident. He issued an order for Zofran to control Resident #442's nausea and vomiting. The APRN arrived at the facility, assessed Resident #442 and issued an order to transfer Resident #442 to an acute care hospital for further evaluation. The APRN documented the hospital admitted Resident #442 with a diagnosis of head injury/concussion. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/25/2025 at 11:30 a.m., in an interview RN Staff B said on 6/7/25 LPN did not inform her Resident #442 had fallen that morning. RN Staff B stated she was not aware of the resident's fall until 12:30 p.m. when he complained of nausea and reported the fall to her. She assessed Resident #442 and notified The APRN of the resident's fall and complaint of nausea and headache. She said when a resident falls, they are required to conduct a fall evaluation at that time and provide post-fall care. RN Staff B said that the nurse should notify the physician, the resident's family, the Unit Manager, the DON and/or the Assistant Director of Nursing as soon as possible. The nurse should also initiate neurological checks if they think the resident hit their head during the fall. On 6/25/25 at 12:00 p.m., in an interview the APRN said on 6/7/25 RN Staff B notified him via text of Resident #442's fall that occurred at approximately 3:00 a.m. that morning. He gave an order for medication for the resident's nausea and vomiting and came to the facility to assess Resident #442. The APRN said Resident #442 was stable when he assessed him but issued an order to transfer him to the hospital for further evaluation. Resident #442's representative was at the facility and chose to drive him to a hospital of their choice. The APRN said when a resident has a fall, the nurse is required to conduct a post-fall assessment, notify the resident's primary care physician, initiate neurological checks, document their assessment and physician orders in the resident's medical record. The APRN confirmed LPN Staff A did not notify him or the physician of Resident #442’s fall. On 6/25/25 at 1:45 p.m., a joint interview was conducted with the DON and the ADON to review the process following a resident’s fall and review Resident #442’s fall investigation. The DON and ADON said their investigation verified that LPN Staff A did not document the resident's fall, did not follow post-fall protocol and did not notify the physician or on-coming shift for post-fall management.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide infection control standards for 2 (Residents #83 and #893) of 2 residents reviewed with urinary catheters.The findings included:Review of Infection Control Policies and Practices dated 2001, revised 2018 states the facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Bullet # 2 states the objectives or our infection control policies are to (a) prevent, detect, investigate, and control infections in the facility. Bullet #4 states All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. Review of Urinary Catheter Policies and Procedures dated 11/30/2014, revised 9/19/2017 states Foley bag to be covered by a privacy bag to preserve dignity of resident and tubing should be off the floor.1. Review of medical record revealed Resident # 83 was initially admitted to the facility on [DATE], the most recent admission date on 6/5/25 with diagnosis including retention of urine (when the bladder doesn't empty completely), unspecified, other obstructive (blocking) and reflux uropathy (urine flows backwards), and sepsis (serious infection).The admission Minimum Data Set (MDS) Assessment with a date of 6/7/25 revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Review of the current physician orders revealed Foley catheter size 16 French (Fr)/30 milliliter (mL) for diagnosis obstructive and reflux uropathy dated 5/14/25. Catheter-bag change as needed dated 5/2/25. Review of the medication administration records (MAR) showed Resident #83 is currently being treated for a urinary tract infection (UTI) identified on 6/22/25 with Levaquin (antibiotic) oral tablet 750 milligrams (mg) once a day for 10 days. Review of care plan initiated 5/15/25 revealed Resident #83 has an indwelling Foley catheter related to obstructive and reflux uropathy. The care plan goal (1) revealed the resident will be/remain free from catheter-related trauma through the review date (2) The resident will show no signs or symptoms of urinary infection through the review date. On 06/23/25 at 10:15 a.m., observed Resident #83 laying in bed. The urinary catheter drainage bag was laying on the floor next to the bed. On 6/23/25 at 10:18 a.m., Certified Nursing Assistant (CNA) Staff F went to the room and said the drainage bag should not be laying on the floor. The CNA said it is an infection control issue because of the germs on the floor. The CNA positioned the urinary drainage bag off the floor by hooking it onto the bedframe. Review of care plan on 6/24/25 revealed Resident #83 has a urinary tract infection related to ESBL (bacteria) in urine. Interventions include contact isolation: wear gowns and mask when changing contaminated linens. Place soiled linens in bags and close bag tightly before taking to laundry. Give antibiotic therapy as ordered. 2. Review of medical record revealed Resident #893 was admitted to the facility on [DATE] with diagnosis including but not limited to urinary tract infection and unspecified dementia. The MDS Assessment with a target date of 6/26/25 revealed a short- and long-term memory problems. Resident is alert to person only.Review of progress note dated 6/21/25 at 2:24 p.m., revealed nursing is reporting today that the resident has not much to void and is concern for potential retention.Review of progress note dated 6/24/25 at 12:14 p.m., revealed the resident developed urine retention over the weekend and Foley was inserted.Review of medical record revealed order 6/22/25 for Foley catheter, diagnosis: urinary retention. Size: 16Fr/5mL.On 6/23/25 at 9:56 a.m., observed Resident #893 with urinary catheter drainage bag without a privacy bag, laying on the floor. *On 6/23/25 at 10:01 a.m., the Director of Nursing (DON) was made aware of the catheter drainage bag laying on the floor next to the resident's bed. The DON stated, Yeah, I need to get that off the floor.*photographic evidence obtained