

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105460	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2025
NAME OF PROVIDER OR SUPPLIER Aviata at North Florida		STREET ADDRESS, CITY, STATE, ZIP CODE 6700 NW 10th Place Gainesville, FL 32605	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to notify the resident's representative and physician of changes in condition for low blood pressures for 1 of 3 residents reviewed for changes in condition (Resident #2). Findings include: Review of Resident #2's admission record documented diagnoses to include pneumonia, unspecified organism, chronic obstructive pulmonary disease with acute exacerbation (an increase in the severity of an illness), acute and chronic respiratory failure with hypercapnia (high carbon dioxide levels in the blood), low back pain unspecified, cognitive communication deficit, other malaise, muscle weakness generalized, orthopnea (shortness of breath that occurs when lying down), dehydration, dependence on supplemental oxygen, hyperlipidemia unspecified (high cholesterol), essential primary hypertension (high blood pressure), and hypercalcemia (high calcium levels in the blood). Review of Resident #2's vitals documented a blood pressure (B/P) of 83/61 mmhg (millimeters of mercury) on 6/9/2025 at 2217 (10:17 PM), a B/P of 80/56 mmhg on 6/10/2025 at 2046 (8:46 PM), a B/P of 83/43 mmhg on 6/12/2025 at 2046 (8:46 PM), and a B/P of 80/48 mmhg on 6/16/2025 at 0044 (12:44 AM). Review of Resident #2's nursing progress notes did not contain documentation on 6/9/2025, 6/10/2025, 6/12/2025, and on 6/16/2025 that Resident #2's representative or physician were notified of the changes in the resident's blood pressure results. During a telephone interview on 10/6/2025 at 6:41 PM, Resident #2's Representative stated, They never called and told me this. They should have let me know when his blood pressures are low. During an interview on 10/7/2025 at 3:10 PM, the Director of Nursing (DON) stated, All staff should administer medications as they are ordered and call the doctor or nurse practitioner if there is any change in vital signs. I don't see notes about his [Resident #2] low blood pressure. We should call and notify the on-call [provider]. It would be a change of condition. There should be a note and notification to his [Resident #2's] [representative] and to his doctor or the on-call nurse practitioner. I don't see that was done. At this point, I question the skill and knowledge of the staff. During a telephone interview on 10/8/2025 at 9:17 AM, Staff M, Licensed Practical Nurse (LPN), stated. I didn't call his [Resident #2's representative] or the nurse practitioner. Sometimes patients have low blood pressure at night. I did not recheck the blood pressure. During a telephone interview on 10/8/2025 at 9:58 AM, Medical Doctor (MD) #1 stated, They [nursing staff] should notify the clinical team for any blood pressures that are in the 80s. I was not notified of this. During a telephone interview on 10/8/2025 at 9:55 AM, the Advanced Practice Registered Nurse (APRN) #3 stated, I was not aware that he [Resident #2] had any blood pressure concerns until the day he left. I was not called by any staff that his blood pressure was low. They should have called and followed the orders or gotten additional orders to hold medications and should recheck blood pressures when they are in the 80s. Review of the policy and procedure titled Change of Condition with the last approval date of 2/7/2025 read, Policy: The center is to promptly notify the patient/resident, the attending physician, and the resident representative when there is a change in the status or condition. Procedure: the nurse is to notify the attending physician and resident representative when there is a (n): significant change in the patient/resident physical, mental, or psychosocial status, need to alter treatment significantly, new treatment. The nurse is to complete an evaluation of the patient/resident. Document the evaluation in the medical record. Notify the patient/resident and the resident representative of the change in condition. Document the notification in the medical record.</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all residents were free from medical neglect by failing to ensure staff implemented the policies and procedures for medication administration for 1 of 3 residents reviewed for intravenous (IV) antibiotic medication administration (Resident #1). The facility failure to ensure residents were free from medical neglect by failing to ensure residents were free from significant medication errors when the residents were not administered the prescribed antibiotics per the physician order and failure to ensure the nursing staff had appropriate IV (intravenously) certification to administer IV medications and follow the policy/procedure related to medication administration, physician notification, obtaining stat [derived from the Latin word statim, meaning immediately] orders for medication and equipment, resulted in Immediate Jeopardy. Resident #1 was admitted on [DATE] with physician orders for Vancomycin 1500 mg IV every 8 hours intravenously for infection (osteomyelitis, an infection in the bone). On 9/8/2025 at approximately 10:00 PM, Resident #1 was administered one incorrect dose of Vancomycin 1000 mg. Resident #1 was not administered any further doses of Vancomycin 1500 mg until 9/12/2025 at 12:00 AM. Resident #1 missed 8 doses of Vancomycin between 9/9/2025 and 9/12/2025. On 9/11/2025, Resident #1 began to experience a change in condition of altered mental status, identified by a family member, who requested on 9/12/2025, that Resident #1 be sent to Emergency Department where he was diagnosed with sepsis [a life threatening emergency that damages the body's organs and can cause death]. Missing antibiotic doses can reduce the effectiveness of the treatment and increase the risk of antibiotic resistance, serious harm and/or death, and lack of staff competency related to nursing staff having appropriate IV certification, can result in serious harm including damage to veins and the injection site, an air embolism, phlebitis, and blood clots, injury and/or death. The Administrator was notified of the Immediate Jeopardy on October 10, 2025, at 11:45 AM. Findings include: Review of the policy and procedure titled Abuse, Neglect, Exploitation & Misappropriation last reviewed 02/07/2025 read, Policy: 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. The management of the facility recognizes these rights and hereby establishes the following statements, policies and procedures to protect these rights to establish a disciplinary policy which results in a fair and timely treatment of occurrences of resident abuse. Employees at the center are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment, and/or misappropriation of property. No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and or misappropriation of property against any resident. Violation of this standard will subject employees to disciplinary action including dismissal provided herein. Definitions: 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. Review of Resident's #1's Discharge summary dated [DATE] from [Name of local hospital] read, Outpatient IV ABX (antibiotic) orders: 1. Cefepime 1 g [gram] q8h [every eight hours] or 3 g q24h [every twenty-four hours] 2. Vancomycin 1500 mg [milligrams] q8h [every eight hours] for 2 weeks. Review of Resident #1's nursing progress note dated 9/8/2025 at 8:31 PM read, Patient was coming around 4:15 PM. With colostomy on his left side and a urostomy on his left side. PICC [Peripherally Inserted Central Catheter] line on his right arm. Vital signs was {sic} within normal range. Patient got left hip surgery paraplegic (related to paraplegia, which is an impairment in motor or sensory function of the lower extremities) and had a drain in the space of the surgery. Patient is alert and oriented times 4. Review of Resident #1's admission record documented an admission date of 9/8/2025 with diagnoses to include subacute osteomyelitis [an infection in the bone], other site, spina bifida occulta [a small gap in one or more of the bones in the spine], other hydrocephalus [a buildup of fluid in the brain], paraplegia unspecified, other bacterial infections of unspecified site, other seizures, local infection of the skin and subcutaneous tissue unspecified, iron deficiency, presence of cerebral spinal fluid drainage device, anemia unspecified, soft tissue disorder unspecified, unspecified visual loss, and gastroesophageal reflux disease [heartburn] without esophagitis [inflammation of the esophagus]. Review of Resident #1's physician order dated 9/8/2025 read, Vancomycin HCl [Hydrochloride, a potent antibiotic used to treat severe bacterial infections, including those resistant to other antibiotics] intravenous solution 1500mg/300ml [1500 milligrams in 300 milliliters of sodium chloride] Use 1500 mg intravenously every 8 hours for infection</p>		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. (continued on next page)

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to ensure midline and central venous access device dressings and flushing were completed according to professional standards of practice for 2 of 3 residents reviewed for intravenous therapy (Residents #3 and #4). Findings include: 1. Review of Resident #3's admission record documented an admission date of 9/25/2025 with diagnoses to include other acute osteomyelitis (an infection of the bone) left ankle and foot, type 2 diabetes mellitus with unspecified complications, acquired absence of left leg below knee, depression unspecified, and unspecified sequela of cerebral infarction (a stroke). Review of Resident #3's physician order dated 10/2/2025 read, May place midline [a midline catheter] for IV [intravenous] antibiotics with Lidocaine if needed. Review of Resident #3's physician order dated 10/3/2025 read, Change dressing on admission or 24 hours after insertion and weekly thereafter and PRN [as needed]. Change dressing as needed and every day shift every Tue [Tuesday] Change dressing weekly. During an observation on 10/7/2025 at 9:15 AM, Resident #3 had a left upper arm single lumen midline catheter with a dressing that was dated 10/3/2025 and gauze under the transparent dressing preventing the insertion site from being observed. During an interview on 10/7/2025 at 9:15 AM, Resident #3 stated, I am getting antibiotics for an infection. I got that IV line a few days ago. The dressing hasn't been changed yet. Review of Resident #3's medical record did not contain documentation of a midline catheter insertion or dressing change 24 hours after insertion of the midline catheter. During an interview on 10/7/2025 at 9:45 AM, Staff B, Licensed Practical Nurse (LPN), stated, It [the midline catheter] has been in since Thursday or Friday [10/2/2025 or 10/3/2025]. The dressing does have gauze under it, and it should have been changed before now. During an observation on 10/8/2025 at 10:15 AM, Staff L, LPN, performed hand hygiene and donned a gown and gloves to administer medications via IV to Resident #3. Staff L cleansed the needleless connector with alcohol. Staff L failed to check the IV patency and position, and administered 10 milliliters (ml) of 0.9% normal saline, and connected the IV antibiotic medication, doffed the gown and gloves, and performed hand hygiene. During an interview on 10/8/2025 at 10:25 AM, Staff L, LPN, stated, I should have checked for a blood return [this indicates the catheter is in the vein]. I should have tried to do that. I think I gave the normal saline fine. 2. Review of Resident #4's admission record documented an admission date of 10/4/2025 with diagnoses to include other streptococcal arthritis left knee, pain in left knee, laceration without foreign body left knee subsequent encounter, localized edema and muscle weakness. Review of Resident #4's physician order dated 10/4/2025 read, Change dressing on admission or 24 hours after insertion and weekly thereafter and PRN every day shift every Tue. During an observation on 10/7/2025 at 9:25 AM, Resident #4 was in bed and had a left upper arm single lumen peripherally inserted central catheter (PICC) line. The dressing was dated 9/29/2025. Review of Resident #4's medication administration record (MAR) for October 2025 documented the dressing change was completed on 10/4/2025 at 1724 (5:24 PM). During an interview on 10/7/2025 at 9:30 AM, Staff B, LPN, stated, The dressing date is showing 9/29/2025 and should have been changed. During an interview on 10/8/2025 at 10:15 AM, Staff G, LPN, stated, I did not do the dressing. I should have done it. I should not have documented that I did it. Review of the policy and procedure titled Catheter Insertion and Care: Midline Dressing Changes with an effective date of 1/17/2019 and the last approval date of 2/7/2025 read, Policy: Midline catheter dressings will be changed at specific intervals, or when needed, to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. General Guidelines: 1. Change midline catheter dressings 24 hours after insertion, every 5-7 days, or if it is wet, dirty, not intact, or compromised in any way. 4. Use a sterile transparent, semi-permeable membrane (TSM) or gauze dressing. If gauze dressing is used, cover the gauze with a TSM and change the dressing every 48 hours. Review of the policy and procedure titled Flushing Central Venous and Midline Catheters with an effective date of 1/17/2019 and the last approval date of 2/7/2025 read, Policy: Midline and central line access devices (CVADs) [Sic.] will be flushed to maintain patency, prevent mixing of incompatible medications and solutions; and to ensure entire dose of solution or medication is administered into the venous system. General Guidelines: Flushing Technique: 2. Use a push-pause or pulsing motion for flushing technique. 3. Aspirate the CVAD catheter for blood to confirm patency prior to administration of medications and solutions. Procedure: Flushing when giving medications: 6. Aspirate slowly for blood return to ensure patency of catheter. 7. Flush with normal saline (amount established by pharmacy of facility protocol) using push-pause method. Review of the policy and procedure titled Catheter Insertion and Care: Central Venous Catheter Dressing Changes with an effective</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 2 of 6 reviewed licensed practical nurses (Staff H, and Staff J) had the specific competency requirements as part of their license and certification to administer IV (intravenous) medications, and 4 of 6 reviewed licensed practical nurses (Staff A, Staff B, Staff E, and Staff G) failed to follow the policy/procedure related to IV medication administration, physician notification, and obtaining stat [derived from the Latin word statim, meaning immediately] orders for medication and equipment for 3 of 3 residents reviewed for intravenous antibiotic medication (Residents #1, #3, and #4), the facility failed to ensure 4 of 6 licensed practical nurses (Staff A, Staff B, Staff J, and Staff L) failed to follow physician-ordered parameters for blood pressure medications for 1 of 3 residents reviewed for medication administration (Resident #2). The facility failure to ensure the nursing staff had appropriate IV (intravenously) certification to administer IV medications and followed the policy/procedure related to medication administration, physician notification, and obtaining stat orders for medication and equipment resulted in Immediate Jeopardy. Resident #1 was admitted on [DATE] with physician orders for Vancomycin 1500 mg IV every 8 hours intravenously for infection (osteomyelitis, an infection in the bone). On 9/8/2025 at approximately 10:00 PM, Resident #1 was administered one incorrect dose of Vancomycin 1000 mg. Resident #1 was not administered any further doses of Vancomycin 1500 mg until 9/12/2025 at 12:00 AM. Resident #1 missed 8 doses of Vancomycin between 9/9/2025 and 9/12/2025. On 9/11/2025, Resident #1 began to experience a change in condition of altered mental status, identified by a family member, who requested on 9/12/2025, that Resident #1 be sent to Emergency Department where he was diagnosed with sepsis [a life threatening emergency that damages the body's organs and can cause death]. Missing antibiotic doses can reduce the effectiveness of the treatment and increase the risk of antibiotic resistance, serious harm and/or death, and lack of staff competency related to nursing staff having appropriate IV certification, can result in serious harm including damage to veins and the injection site, an air embolism, phlebitis, and blood clots, injury and/or death. The Administrator was notified of the Immediate Jeopardy on October 10, 2025, at 11:45 AM. Findings include: 1) Review of Resident's #1's Discharge summary dated [DATE] from [Name of local hospital] read, Outpatient IV ABX (antibiotic) orders: 2. Vancomycin 1500 mg [milligrams] q8h [every eight hours] for 2 weeks. Review of Resident #1's admission record documented an admission date of 9/8/2025 with diagnoses to include subacute osteomyelitis [an infection in the bone], other site, spina bifida occulta [a small gap in one or more of the bones in the spine], other hydrocephalus [a buildup of fluid in the brain], paraplegia (an impairment in motor or sensory function of the lower extremities) unspecified, other bacterial infections of unspecified site, other seizures, local infection of the skin and subcutaneous tissue unspecified, iron deficiency, presence of cerebral spinal fluid drainage device, anemia unspecified, soft tissue disorder unspecified, unspecified visual loss, and gastroesophageal reflux disease [heartburn] without esophagitis [inflammation of the esophagus]. Review of Resident #1's nursing progress note dated 9/8/2025 at 8:31 PM read, Patient was coming around 4:15 PM. With colostomy on his left side and a urostomy on his left side. PICC [Peripherally Inserted Central Catheter] line on his right arm. Vital signs was {sic} within normal range. Patient got left hip surgery paraplegic and had a drain in the space of the surgery. Patient is alert and oriented times 4. Review of Resident #1's physician order dated 9/8/2025 read, Vancomycin HCl [Hydrochloride, a potent antibiotic used to treat severe bacterial infections, including those resistant to other antibiotics] intravenous solution 1500mg/300ml [1500 milligrams in 300 milliliters of sodium chloride] Use 1500 mg intravenously every 8 hours for Infection for 21 Days. Review of Resident #1 Medication Administration Record for the month of September 2025 for Vancomycin 1500 mg intravenously was documented as being administered on 9/8/2025 at or around 2200 [10:00 PM] by Staff E., LPN. Review of Resident #1's Medication Administration Record for the month of September 2025 for vancomycin 1500 mg intravenously was documented as chart code 9 (other see nurses notes) on 9/9/2025 at 0800 (8:00 AM) and 1600 (4:00 PM), on 9/10/2025 there is an X [not given] at 12:00 midnight and a chart code of 9 at 0800 [8:00 AM] and 1600 (4:00 PM). On 9/11/2025 a chart code of H [hold] at 1200 [12:00 AM], 0800, and 1600 for a total of 8 missed doses of vancomycin. Review of Resident #1 Medication Administration Record for the month of September 2025 for Vancomycin HCl Intravenous Solution 1500mg documented on 9/12/2025 at 0000 [12:00 AM] administered by Staff J, LPN (Licensed Practical Nurse). Review of Resident #1's EMAR (electronic medication administration record) note for vancomycin 1500 mg IV dated 9/9/2025 at 7:32 AM</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Based on interview and record review, the facility failed to ensure physician-ordered parameters were followed related to hypertensive medications, resulting in the administration of unnecessary medications for 1 of 3 residents reviewed for medication administration (Resident #2). Findings include: Review of Resident #2's admission record documented diagnoses to include pneumonia, unspecified organism, chronic obstructive pulmonary disease with acute exacerbation (an increase in the severity of an illness), acute and chronic respiratory failure with hypercapnia (high carbon dioxide levels in the blood), low back pain unspecified, cognitive communication deficit, other malaise, muscle weakness generalized, orthopnea (shortness of breath that occurs when lying down), dehydration, dependence on supplemental oxygen, hyperlipidemia unspecified (high cholesterol), essential primary hypertension (high blood pressure), and hypercalcemia (high calcium levels in the blood). Review of Resident #2's physician order dated 4/25/2025 read, Metoprolol Tartate Oral Tablet 25 mg [milligram] (Metoprolol Tartate), give 0.5 tablet by mouth two times a day for HTN [hypertension]. Hold for SBP [Systolic Blood Pressure] < [less than] 110 or HR [heart rate] <70. Review of Resident #2's Medication Administration Record (MAR) for April 2025 documented Metoprolol was administered on 4/28/2025 at 0900 (9:00 AM) with a blood pressure (B/P) of 107/72, on 4/28/2025 at 2100 (9:00 PM) with a B/P of 101/68. Review of Resident #2's MAR for May 2025 documented Metoprolol was administered at 0900 on 5/12/2025 with a B/P of 102/77, on 5/16/2025 with a B/P of 109/58, on 5/24/2025 with a B/P of 101/64, on 5/30/2025 with a B/P of 100/57 and at 2100 on 5/8/2025 with a B/P of 98/62, on 5/13/2025 with a B/P of 106/67, on 5/22/2025 with a B/P of 98/64, and on 5/23/2025 with a B/P of 102/62. Review of Resident #2's MAR for June 2025 documented Metoprolol was administered at 0900 on 6/1/2025 with a B/P of 106/54, on 6/2/2025 with a B/P of 102/65, and on 6/16/2025 with a B/P of 96/52, and at 2100 on 6/5/2025 with a B/P of 98/63, on 6/14/2025 with a B/P of 107/82, and on 6/15/2025 with a B/P of 80/48. During an interview on 10/7/2025 at 1:00 PM, Staff A, Licensed Practical Nurse (LPN), stated, I'm not sure if I gave the medication, but I will usually put in that I held it, my initials mean it was given. We should follow orders and not administer medications outside parameters. During an interview on 10/7/2025 at 1:53 PM, Staff B, LPN, stated, I was not told that he [Resident #2] had any hypotension [low blood pressure] the night before. I would not have given his blood pressure medications. I would have held them. I can't remember if there were parameters for the medication. During an interview on 10/7/2025 at 3:10 PM, the Director of Nursing (DON) stated, I was not here during that time. I was not aware of any concerns related to his [Resident #2] care. All staff should administer medications as they are ordered and call the doctor or nurse practitioner if there is any change in vital signs. During a telephone interview on 10/7/2025 at 3:55 PM, Staff J, LPN, stated, I must have given it if I didn't document that I held the medicine. I don't really know, but if I documented I gave it I must have. We should follow the parameters if a medicine has them. During an interview on 10/8/2025 at 8:51 AM, the Advanced Practice Registered Nurse (APRN) #1 stated, I would not expect the staff to administer blood pressure medications outside the parameters. During a telephone interview on 10/8/2025 at 9:58 AM, the Medical Doctor (MD) stated, The staff should follow all orders with parameters and not administer them [medications] outside of those. I was not notified of this. During an interview on 10/8/2025 at 10:27 AM, Staff L, LPN, stated, I did give the medication [Metoprolol]. I'm not sure why I didn't hold it. Review of the policy and procedure titled Administering Medications with the last review date of 02/07/2025 read, Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation. 2. The Director of Nursing Services supervises and directs all personnel who administer medication and/or have related functions. 4. Medications are administered in accordance with prescriber orders, including any required time frame.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105460	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2025
NAME OF PROVIDER OR SUPPLIER Aviata at North Florida		STREET ADDRESS, CITY, STATE, ZIP CODE 6700 NW 10th Place Gainesville, FL 32605	

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)
<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105460	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2025
NAME OF PROVIDER OR SUPPLIER Aviata at North Florida		STREET ADDRESS, CITY, STATE, ZIP CODE 6700 NW 10th Place Gainesville, FL 32605	
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)		
<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from significant medication errors when the facility failed to ensure residents were administered physician ordered antibiotics for 1 of 3 residents reviewed for intravenous (IV) antibiotic medication (Resident #1). The facility failure to ensure residents were free from significant medication errors when the residents were not administered the prescribed antibiotics per the physician order resulted in Immediate Jeopardy. Resident #1 was admitted on [DATE] with physician orders for Vancomycin 1500 mg IV every 8 hours intravenously for infection (osteomyelitis, an infection in the bone). On 9/8/2025 at approximately 10:00 PM, Resident #1 was administered one incorrect dose of Vancomycin 1000 mg. Resident #1 was not administered any further doses of Vancomycin 1500 mg until 9/12/2025 at 12:00 AM. Resident #1 missed 8 doses of Vancomycin between 9/9/2025 and 9/12/2025. On 9/11/2025, Resident #1 began to experience a change in condition of altered mental status, identified by a family member, who requested on 9/12/2025, that Resident #1 be sent to Emergency Department where he was diagnosed with sepsis [a life threatening emergency that damages the body's organs and can cause death]. Missing antibiotic doses can reduce the effectiveness of the treatment and increase the risk of antibiotic resistance, serious harm and/or death. The Administrator was notified of the Immediate Jeopardy on October 10, 2025, at 11:45 AM. Findings include: Review of Resident #1's admission record documented an admission date of 9/8/2025 with diagnoses to include subacute osteomyelitis [an infection in the bone], other site, spina bifida occulta [a small gap in one or more of the bones in the spine], other hydrocephalus [a buildup of fluid in the brain], paraplegia (an impairment in motor or sensory function of the lower extremities) unspecified, other bacterial infections of unspecified site, other seizures, local infection of the skin and subcutaneous tissue unspecified, iron deficiency, presence of cerebral spinal fluid drainage device, anemia unspecified, soft tissue disorder unspecified, unspecified visual loss, and gastroesophageal reflux disease [heartburn] without esophagitis [inflammation of the esophagus]. Review of Resident's #1's Discharge summary dated [DATE] from [Name of local hospital] read, Outpatient IV ABX (antibiotic) orders: 1. Cefepime 1 g [gram] q8h [every 8 hours] or 3 g q24h [every twenty-four hours]. 2. Vancomycin 1500 mg [milligrams] q8h for 2 weeks. Review of Resident #1's physician order dated 9/8/2025 read, Vancomycin HCl [Hydrochloride, a potent antibiotic used to treat severe bacterial infections, including those resistant to other antibiotics] intravenous solution 1500mg/300ml [1500 milligrams in 300 milliliters of sodium chloride] Use 1500 mg intravenously every 8 hours for Infection for 21 Days. Cefepime HCl [used to treat severe bacterial infections] intravenous solution 1 gm/50 ml (Cefepime HCl) Use 1 gram intravenously every 8 hours for infection for 21 days until finished. Review of Resident #1's MAR dated 9/8/2025 documented Vancomycin HCl intravenous solution 1500 mg/300 ml (Vancomycin HCl) Use 1500 mg intravenously every 8 hours for infection for 21 days at 0600 (6:00 AM), 1400 (2:00 PM), and 2200 (10:00 PM). Review of a form titled [Name of Pharmacy Provider] Transactions by Patient, C14 [Form Code] date 9/8/2025 documented vancomycin 1 gm one vial was removed at 7:50 PM, cefepime 1 gm two vials were removed, one at 7:49 PM and one at 7:53 PM. One bag of sodium chloride inj (injectable) 100 ml bag was removed at 7:55 PM from the [name of the automated medication dispensing machine] for [Resident #1's name]. Additional interviews were attempted 10/8/2025 and 10/9/2025 with Staff E, LPN via telephone to provide clarification of the removal of 100 ml of sodium chloride and vancomycin 1 gram and two vials of cefepime and no additional sodium chloride removed from the automated medication dispensing machine for vancomycin and cefepime IV administration. The physician orders document vancomycin 1500 mg (1.5 grams) in 300 ml of sodium chloride and cefepime in 50 ml of sodium chloride. On the date of the exit, 10/10/2025, no return call was received. Review of Resident #1's MAR dated 9/8/2025 documented vancomycin 1500 mg and cefepime 1 gram was administered IV at approximately 10:00 PM by the initialing of the MAR by Staff E, LPN. Review of the form titled [Name of pharmacy] Inventory on Hand dated 9/9/2025 documented vancomycin 1 gm [gram] vial on hand amount 4 vials were in the [name of the automated medication dispensing machine]. Review of Resident #1's physician order dated 9/9/2025 read, Vancomycin intravenous solution 1500 mg [milligrams]/300 ml [milliliters] (Vancomycin HCl [hydrochloride]) use 1500 mg intravenously every 8 hours for Infection for 21 Days. [Scheduled for 0000 (12:00 AM), 0800 (8:00 AM), and 1600 (4:00 PM)]. Review of Resident #1's Medication Administration Record for the month of September 2025 for vancomycin 1500 mg intravenously was documented as chart code 9 (other see nurses notes) on</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105460	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2025
NAME OF PROVIDER OR SUPPLIER Aviata at North Florida		STREET ADDRESS, CITY, STATE, ZIP CODE 6700 NW 10th Place Gainesville, FL 32605	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105460	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2025
NAME OF PROVIDER OR SUPPLIER Aviata at North Florida		STREET ADDRESS, CITY, STATE, ZIP CODE 6700 NW 10th Place Gainesville, FL 32605	
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)		
<p>F 0842</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 interview and record review, the facility failed to ensure complete and accurate documentation of medical records for 3 of 4 residents reviewed for intravenous therapy documentation (Residents #1, #2, and #3). Findings include: 1. Review of Resident #2's admission record documented diagnoses that include pneumonia, unspecified organism, chronic obstructive pulmonary disease with acute exacerbation (an increase in the severity of an illness), acute and chronic respiratory failure with hypercapnia (high carbon dioxide levels in the blood), low back pain unspecified, cognitive communication deficit, other malaise, muscle weakness generalized, orthopnea (shortness of breath that occurs when lying down), dehydration, dependence on supplemental oxygen, hyperlipidemia unspecified (high cholesterol), essential primary hypertension (high blood pressure), and hypercalcemia (high calcium levels in the blood). Review of Resident #2's physician order dated 6/13/2025 read, Please insert PIV [Peripheral Intravenous] for dehydration. One time only for IV [intravenous] access for 1 Day. Review of Resident #2's nursing progress notes from 6/12/2025 through 6/16/2025 showed no documentation of peripheral intravenous line insertion. During an interview on 10/7/2025 at 3:10 PM, the Director of Nursing (DON) stated, I was not aware of any concerns related to his [Resident #2] care. There should be documentation of all care provided. I do not see any documentation about the IV insertion and there should be. They [the nursing staff] should document where the IV is, how many times it took to get a line, if they were successful or not, and what fluids were running and if the site was okay. During an interview on 10/7/2025 at 1:53 PM, Staff B, Licensed Practical Nurse (LPN), stated, It was close to end of day, his [Resident #2's] [representative] had questions that I could not answer. Why were fluids hanging? It was a full bag [of IV fluids] that was hanging and why had an IV been placed, because there were no orders. I didn't see any orders for IV fluids or the IV when I was talking to her. But once the order is complete, they will fall off the MAR [Medication Administration Record], so I needed to look at them. I did not flush or do anything that day with his IV. 2. Review of Resident #3's admission record documented an admission date of 9/25/2025 with diagnose to include other acute osteomyelitis (an infection of the bone) left ankle and foot, type 2 diabetes mellitus with unspecified complications, acquired absence of left leg below knee, depression unspecified, and unspecified sequela of cerebral infarction (a stroke). Review of Resident #3's record titled Admission/Readmission read, Section H: Vascular Access: 1. IV present: 2: checked yes. 2. Type: 1. Peripheral checked. 3. Location: arm right. Review of Resident #3's physician order dated 9/26/2025 read, May remove peripheral IV. One time only for 1 day. Review of Resident #3's nursing progress notes from 9/25/2025 through 10/2/2025 showed no notes related to the removal of the peripheral IV. 3. Review of Resident #1's admission record documented an admission date of 9/8/2025 with diagnoses to include subacute osteomyelitis [an infection in the bone], other site, spina bifida occulta [a small gap in one or more of the bones in the spine], other hydrocephalus [a buildup of fluid in the brain], paraplegia (an impairment in motor or sensory function of the lower extremities) unspecified, other bacterial infections of unspecified site, other seizures, local infection of the skin and subcutaneous tissue unspecified, iron deficiency, presence of cerebral spinal fluid drainage device, anemia unspecified, soft tissue disorder unspecified, unspecified visual loss, and gastroesophageal reflux disease [heartburn] without esophagitis [inflammation of the esophagus]. Review of Resident #1's physician order dated 9/8/2025 read, Vancomycin HCl [Hydrochloride, a potent antibiotic used to treat severe bacterial infections, including those resistant to other antibiotics] intravenous solution 1500mg/300ml [1500 milligrams in 300 milliliters of sodium chloride] Use 1500 mg intravenously every 8 hours for Infection for 21 Days. Review of Resident #1's physician order dated 9/8/2025 read, Cefepime HCl (antibiotic used to treat a wide variety of serious bacterial infections) intravenous solution 1 gm/50 ml [1 gram per 50 milliliter] (Cefepime HCl (hydrochloride)) Use 1 gram intravenously every 8 hours for infection for 21 Days until finished. Review of Resident #1's Medication Administration Record for the month of September 2025 for vancomycin 1500 mg intravenously was documented as chart code 9 (other see nurses notes) on 9/9/2025 at 0800 (8:00 AM) and 1600 (4:00 PM), on 9/10/2025 there is an X [not given] at 12:00 midnight and a chart code of 9 at 0800 [8:00 AM] and 1600 (4:00 PM). On 9/11/2025 a chart code of H [hold] at 1200 [12:00 AM], 0800, and 1600 for a total of 8 missed doses of vancomycin. Review of Resident #1's MAR for cefepime dated 09/9/2025 at 6:00 AM documented a code of 5 (Hold/see Nurses Notes) and 1400 (2:00 PM) a code of 9 (Other/See Nurses Notes). For a total of two missed doses During an interview on 10/07/2025 at 1:36 PM Staff A Licensed Practical Nurse (LPN)</p>		