

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/30/2025
NAME OF PROVIDER OR SUPPLIER Aviata at Brentwood		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 N Brentwood Cir Lecanto, FL 34461	

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 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>Based on record review and interview, the facility failed to implement the discharge policy developed to ensure follow up with discharged residents for 1 resident (Resident #2) of 3 residents reviewed for discharge. Findings include: Review of Resident #2's admission record showed the resident was admitted with diagnoses that included sepsis, acute respiratory failure with hypoxia, type 2 diabetes mellitus with ketoacidosis and hyperglycemia without coma, acquired absence of right leg below knee, encounter for orthopedic aftercare, acquired absence of right great toe, morbid severe obesity due to excess calories and encounter for surgical aftercare, and discharged on 6/17/2025. During an interview on 6/30/2025 beginning at 10:44 AM, Staff A, Case Manager, stated, [Resident #2's name] elected to discharge home from the facility on 6/17/2025 after his insurance company discontinued payments for skilled services. I called [Resident #2's name] insurance company and they told me to set up home health care with their parent company. The insurance company would set up day of discharge home health care and gave me a reference number for the home health services. I found out on 6/20/2025 that home health services have not been to [Resident #2's name] home. I contacted [Resident #2's name] parent insurance company that told home health services have not been set up for [Resident #2's name] because of the limitations of his plan. I do not know why [Resident #2's name] parent insurance company has provided a reference number for home health services. I did not follow up with [Resident #2's name] to verify home health services are being provided to [Resident #2's name]. I did not do a follow up call. I just forgot to give him a follow-up call. I have not talked to him. During an interview on 6/30/2025 at 10:48 AM, the Director of Nursing stated, My expectation is that a follow-up call is made to discharged residents to check on them. During an interview on 6/30/2025 at 11:12 AM, the Administrator stated, [Resident #2's name] discharged from the facility on 6/17/2025 due to his insurance company declining to pay for additional skilled services. I was notified by adult protective services on 6/20/2025 that [Resident #2's name] was not receiving home health services. Review of the facility policy and procedures titled Discharge Planning last reviewed on 5/22/2025 read, Procedure. 6. Within twenty-four (24) to forty-eight (48) hours (or next day) after discharge to home, another nursing facility or to another type of residential facility such as a board-and-care home, a follow up phone call, or if necessary, home visit will be made to ascertain that community services/referrals are indeed being provided according to the discharge plan.</p>

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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