STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105461	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Brentwood	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure accuracy of minimum data set assessments for 1 of 3 residents reviewed for dialysis (Resident #6).Findings include:Review of Resident #6's physician order dated 4/29/2025 read, Hemodialysis- Tuesday, Thursday and Saturday- [Address and Phone number of Dialysis Center].Review of Resident #6's quarterly Minimum Data Set assessment dated [DATE] showed dialysis was not checked under Section O- Special Treatments, Procedures and Programs.During an interview on 11/4/2025 at 12:44 PM, the Director of Nursing stated, [Resident #6's name] is a dialysis patient.During an interview on 11/4/2025 at 12:47 PM, the Minimum Data Set Registered Nurse stated, [Resident #6's name] is a dialysis patient. Section O would need to be corrected. We follow the RAI [Resident Assessment Instrument] manual.

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 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. Based on observation, interview, and record review, the facility failed to ensure residents received blood pressure medications as ordered for 1 of 3 residents reviewed for medication management (Resident #6). Findings include: Review of Resident #6's physician order dated 10/9/2025 read, Midodrine HCl Oral Tablet 5 MG [milligram] (Midodrine HCl), Give 5 mg by mouth every 12 hours as needed for hypotension. Give for Systolic BP [Blood Pressure] less than 110 and diastolic BP less than 60.Review of Resident #6's Weights and Vitals Summary showed the blood pressure of 105/54 mmHg [millimeters of mercury] on 10/11/2025 at 5:04 PM and 102/50 mmHg on 10/11/2025 at 11:19 PM.Review of Resident #6's Medication Administration Record (MAR) for October 2025 for administration of Midodrine HCl 5 mg showed no documentation on 10/11/2025.During an interview on 11/5/2025 at 9:55 AM, the Advanced Practice Registered Nurse #1 stated, On 10/11/2025, the on call notes did not mention anything about blood pressure, but Midodrine was already at hand. Parameters are ordered for a reason. [Resident #6's name] blood pressure some days was through the roof and some days was lower than normal. Not sure if the staff had checked her blood pressure and then rechecked the blood pressure and it had recovered.During an interview on 11/5/2025 at 10:42 AM, Staff A, Licensed Practical Nurse (LPN), stated, On 10/11/2025, I was checking on [Resident #6's name] and she had no signs of distress throughout the day. I don't recall why the medication is not marked as given. I always look at parameters. If I would have given the medication, I would have documented on the MAR. During an interview on 11/5/2025 at 12:08 PM, the Director of Nursing stated, Midodrine should have been given and parameters should have been followed.Review of the facility policy and procedure titled Medication- Oral Administration of with an effective date of 11/30/2014 read, Procedure. Review physician's order.

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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 record review and interview, the facility failed to ensure medical records were accurate for 3 of 10 sampled residents (Residents #3, #4, and #5).Findings include: 1) Review of Resident #3's clinical record revealed an incident report dated 10/17/2025 that documented, At approximately 1645 [4:45 PM] [Resident #3's Name] was found lying on the floor on the left side of his bed lying on his right side. The right side of his forehead had a large actively bleeding laceration, as well as a skin tear on the right knee and right hand. His right eye was swollen shut and has a hematoma near the eyebrow. Other info: Attempted to climb out of bed on his own and unaware of his limitations. Review of Resident #3's hospital Discharge summary dated [DATE] read, Patient is a [AGE] year old male who presented in a c-collar [cervical collar] and not on a backboard as a level 1 trauma alert by air after a ground level fall. Per EMS [Emergency Medical Services] report, patient came from assisted living facility [Sic.] after a fall. It was reported that patient fell forward and onto his head and face. Patient was found to have the following injuries: - Nondisplaced fracture of the right orbital floor. No herniation of intraconal fat. - Nondisplaced fracture of the anterior wall the right maxillary sinus. - Comminuted, minimally displaced fracture of the lateral wall of the right maxillary sinus. - Right forehead scalp laceration and subcutaneous hematoma. - Right preseptal soft tissue swelling. - Small right frontoparietal subdural hematoma measuring up to 2 mm [millimeters]. Review of Resident #3's fall risk evaluation dated 10/31/2025 read, History of falling (Immediate or previous [within the last 6 months])? No. The fall risk evaluation documented Resident #3's fall risk score as 35 with a category assignment of Low Risk. During an interview on 11/4/2025 at 12:40 PM, the Director of Nursing stated, Well that's [Resident #3's fall risk assessment dated [DATE]] incorrect. 2) Review of Resident #4's physician order dated 9/18/2025 read, Wound Care: Sacrum-Cleanse with NS [Normal Saline]- pat dry- apply collagen and calcium alginate- skin prep periwound- cover with superabsorb every day shift. Review of Resident #4's Treatment Administration Record (TAR) for October 2025 for wound care of sacrum cleansing with normal saline and applying collagen and calcium alginate showed no entry documented on 10/3/2025. Review of Resident #4's physician order dated 10/3/2025 read, Wound Care: Sacrum- Cleanse with NS- pat dry- gently pack with collagen sheet and calcium alginate- skin prep periwound-cover with superabsorb dressing every day shift. Review of Resident #4's TAR for October 2025 for wound care of sacrum cleansing with normal saline and gently packing with collagen sheet and calcium alginate showed no entries documented on 10/5/2025 and 10/9/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's physician order dated 10/3/2025 read, Wound Care- (R) [Right] Lateral thigh- cleanse with N/S, cover with hydrocolloid dressing, every day shift. Review of Resident #4's TAR for October 2025 for wound care for the right lateral thigh showed no entry documented on 10/5/2025. Review of Resident #4's physician order dated 10/20/2025 read, Wound Care: Sacrum- Cleanse with Dakins- pat dry- apply Dakins Moistened Kerlix packing- cover with a superabsorbent every day shift. Review of Resident #4's TAR for October 2025 wound care of sacrum cleansing with Dakins and applying Dakins moistened kerlix showed no entry documented on 10/29/2025. Review of Resident #4 TAR for November 2025 for wound care of the sacrum cleansing with Dakins and applying Dakins moistened kerlix showed no entry documented on 11/1/2025. During an interview on 11/5/2025 at 11:23 AM, the Wound Care Nurse stated, Resident #4's name] will refuse care at times depending on her mood. She would refuse wound care from floor nurses. Since I have been doing her care, she has not refused. I don't know why her wound care treatment record has blanks. Maybe she has been hospitalized . A lot of times wound care would fall on the nurse on the cart to do the wound care, not sure why there are blanks. During an interview on 11/5/2025 at 12:08 PM, the Director of Nursing (DON) stated, The treatment record should not have any blanks. The nurses are to document accurately the treatment provided and if resident refused should document accordingly. 3) Review of Resident #5's Medication Administration Record (MAR) for September 2025 for administration of Aspirin 81 Oral Tablet Chewable (Aspirin), Give 1 tablet by mouth one time a day for preventative showed code 8 (nausea/vomiting) documented on 9/25/2025 at 9:00 AM. Review of Resident #5's progress note dated 9/25/2025 read, Nausea reported. New admit medication not on hand. will contact MD [Medical Doctor] regarding nausea. During an interview on 11/5/2025 at 8:04 AM, the Director of Nursing stated, Per the nurse [Staff B's name], she said he [Resident #5] was nauseous and she held the mediation. She mentions she would contact the provider and then circle back to the resident and later it resolved and the provider did come and see him shortly after and no complaints of nausea. Per [Staff B's name] he was refusing medication because he was nauseous. During an interview on 11/5/2025 at 11:58 AM, Staff B, Registered Nurse (RN), stated, The provider came to see him [Resident #5]. I went in. He was nauseous. I didn't contact the provider because I when back to check on him when I finished my med pass and he was fine. I don't remember, I don't want to misspeak. It should be documented. During an interview on 11/5/2025 at 1:26 PM, the Advanced Practice Registered Nurse (APRN) #2 stated, I really cannot say if not having that medication could affect him. I don't recall if they notified me about the medications. [Resident #5's name] had no alarming vitals that would concern me that were documented. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/5/2025 at 2:06 PM, the DON stated, The nurse should have documented her action when she circled back with the resident to have a better understanding of what happened. During an interview on 11/5/2025 at 12:07 PM, the Regional Nurse Consultant stated, We do not have a documentation policy.