

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 12/12/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on record review and interview, the facility failed to ensure the resident representative was notified of a sustained fall for 1 of 3 residents reviewed, Resident #129. Findings include: Review of Resident #129's SBAR (Situation, Background, Assessment, and Recommendation) Communication form showed the resident had a fall on 1/25/2025. Further review of the form showed it documented, [Resident #129's representative's name] she is emergency contact and there is no number for her and daughter as well but no numbers to call family. The form was signed by Staff E, Licensed Practical Nurse (LPN). During an interview on 12/9/2025 at 9:36 AM, Resident #129's Granddaughter stated, No one notified of the fall when it happened. I came into the facility and saw my grandmother's knees were a bloodbath. I called the unit manager on facetime and showed her what my grandmother looked like. She had me hold and that is when [Staff B, LPN's name] told me of the fall. During an interview on 12/9/2025 at 1:38 PM, Staff B, Licensed Practical Nurse (LPN), stated, [Resident #129' name's] granddaughter called me on a facetime. She was concerned with bruising. I asked her to let me see what she was talking about. I did not know at the time of the fall, when I checked the computer, I informed her of the fall. The nurse did call and could not reach her. If they had called me, I perhaps gotten a hold of her. At that time, I was the unit manager and was on call that day [1/25/2025] the fall happened. During an interview on 12/9/2025 at 3:00 PM, Staff E, LPN, stated, I cannot remember if I contacted the family or not. Review of the facility policy and procedure titled Notification of Change in Condition with the last review date of 5/20/2025 read, Policy: The Center 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 to notify the attending physician and Resident Representative when there is a(an): Accidents.</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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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received care and services under restorative nursing program as recommended by therapy department for 2 of 6 residents reviewed for restorative services, Residents #62, and #109.</p> <p>Findings include:</p> <p>1) Review of Resident #62's occupational therapy discharge summary, dates of service 10/23/2025 to 11/8/2025, read, Discharge Recommendations: Restorative nursing plan. Restorative Program Established/Trained= Restorative Bed Mobility Program. Bed Mobility Program Established/Trained: rolling, sitting at EOB [Edge of Bed]. Prognosis: Prognosis to Maintain CLOF [Current Level of Functioning] = Good with consistent staff follow-through.</p> <p>Review of Resident #62's clinical records revealed no documentation indicating the resident received restorative nursing as recommended by the occupational therapist.</p> <p>During an interview on 12/10/2025 at 12:40 PM, the Director of Nursing confirmed Resident #62's clinical record did not include documentation indicating the facility had provided restorative nursing to Resident #62 as recommended by the occupational therapist. She confirmed the facility did not have a restorative nursing program.</p> <p>During an interview on 12/12/2025 at 8:30 AM, the Director of Nursing was unable to explain why the facility did not have a restorative nursing program and could not provide a date on which restorative program ended.</p> <p>2) During an interview on 12/12/2025 at 8:40 AM, Resident #109 stated she had not had therapy for a while and would like to have therapy if it was offered to her.</p> <p>Review of Resident #109's physical therapy discharge summary, date of service 6/7/2025 to 9/12/2025 read, Progress & Response to Treatment: Pt [patient] has made good progress towards all goal areas with decreased assistance with bed mobs, transfers and gait. Patient does fluxuate [Sic.] with respiratory deficits requiring frequent rest periods. Patient also presents with occasional knee bucking in standing making patient at continue risk for falls. Patient discharged at this time with RNP [Restorative Nursing Program].</p> <p>During an interview on 12/11/2025 at 10:44 AM, the Rehabilitation Director stated, [Resident #109's name] was responsive she was discharged with supervision when ambulating. She was discharged because she met her maximum potential and recommend to go to the restorative program. I was not aware the facility does not have a restorative program.</p> <p>During an interview on 12/12/2025 at 9:50 AM, the Director of Nursing stated that the facility had not had a restorative program for a couple of months.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy and procedures titled Restorative Nursing Services with the last review date of 5/20/2025 read, Policy: The center provides restorative nursing to encourage and enable residents to be as independent as possible based on their individual condition, and goals. Restorative nursing programs are considered for residents who: Are not a candidate for rehab services. Benefit from restorative along with rehab services.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to take action on the results of laboratory testing in a timely manner for 1 of 3 residents reviewed for laboratory services, Resident #129. Findings include: Review of Resident #129's admission record documented the resident was admitted on [DATE] with diagnoses that included type 2 diabetes mellitus with hyperglycemia, anemia, long term (current) use of insulin, and chronic kidney disease. Review of physician initial encounter note dated 12/9/2024 read, HPI [History of Present Illness] [Resident #129's name] is an [AGE] year-old female who presented to Aspire Brentwood after evaluation at a local hospital for urinary retention and altered mental status. She was found to have a urinary tract infection and was started on intravenous antibiotics; the infection was likely responsible for her altered mental status. She was dehydrated and received intravenous fluids. Her diabetes was uncontrolled and was managed with insulin. During her hospital stay, she improved and participated in physical and occupational therapy. Due to her weakness and overall medical condition, it was determined she would benefit from continued medical and therapy care at a rehabilitation facility. Plan: Cont. [continue] meds [medications] for DM-II [type 2 diabetes mellitus]- Glipizide, Pioglitazone, Accuchecks AC/HS [blood sugar checks before meals and at bed time], Sliding scale insulin. Review of Resident #129's physician orders showed a lab order dated 12/9/2024 that included Hemoglobin A1C (measures the average blood sugar (glucose) levels over the past two to three months). Review of Resident #129's Lab Results Report with the reported date of 12/11/2024 showed the hemoglobin A1C of 10.8. Review of Resident #129's nursing progress notes revealed no notification of the reported results to the physician. Review of Resident #129's physician order dated 12/21/2024 read, Lantus Subcutaneous Solution 100 unit/ml [milliliter] (Insulin Glargine), Inject 10 unit subcutaneously at bedtime related to type 2 diabetes mellitus with hyperglycemia, Hold if BS [blood sugar] less than 126. Review of Resident #129's physician order dated 12/21/2024 read, Insulin Lispro Injection Solution (Insulin Lispro), Inject as per sliding scale: if 0-150= 0; 151-200= 2 units; 201-250= 4 units; 251-300= 6 units; 301-350= 8 units; 351-400= 10 units; 401-499= 12 units, Call MD [Medical Doctor], subcutaneously before meals and at bedtime related to type 2 diabetes mellitus with hyperglycemia. During an interview on 12/9/2025 at approximately 2:00 PM, the Director of Nursing (DON) stated, The physician should have been notified of these results. During an interview on 12/10/2025 at 2:30 PM, Resident #129's physician stated, Vaguely remember the resident, cannot say that the facility has a history of not reporting lab results or problems. It could simply be an oversight. It was so long ago, cannot answer with any certainty if they report results to me.</p>		