

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105531	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/24/2025
NAME OF PROVIDER OR SUPPLIER  Aviata at San Jose		STREET ADDRESS, CITY, STATE, ZIP CODE  9355 San Jose Blvd Jacksonville, FL 32257	
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51956</p> <p>Based on observations, interviews, and record review, the facility failed to assist one resident (#81) in a total survey sample of 38 residents, to voice grievances. The facility failed to make prompt efforts to resolve a grievance and to keep the residents appropriately apprised of progress toward resolution. Failure to file and investigate grievances promptly placed the Resident at risk of further potential violations of resident rights. There were 38 residents in the total sample.</p> <p>The findings include:</p> <p>During an interview on 4/21/25 at 12:10 PM, Resident #81 voiced concerns regarding her care. She stated she pressed her call light on the evening of 4/15/25, because she needed assistance and was having a bowel movement. The resident stated it took over two hours for staff to respond to her request for assistance. When assigned staff arrived, she stated they did not want to clean her up because she was still having a bowel movement. The resident reported that she had spoken to the Social Services Assistant (SSA) during morning guardian angel rounds, regarding the Certified Nursing Assistant (CNA) not cleaning her and leaving her in that condition. She further reported to the SSA that she wanted to file a grievance regarding the issue. The SSA stated she would relay the information during the morning meeting. The resident stated she had not received any updates on the issue to date.</p> <p>On 4/23/25 at 11:20 AM, a follow-up interview was conducted with Resident #81. She said, I have not heard back from the facility staff regarding the grievance I asked the SSA to file regarding delays in care, and I would like to know what was done.</p> <p>A review of the resident's medical record revealed an admitted [DATE]. Her diagnoses included, but were not limited to, chronic atrial fibrillation, unspecified diastolic (congestive) heart failure, morbid obesity, moderate protein-calorie malnutrition, venous insufficiency, anemia, major depressive disorder, lymphedema, essential (primary) hypertension, and chronic pain syndrome.</p> <p>A review of the resident's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 1/3/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 possible points, indicating intact cognition. Further, it revealed that the resident required maximum assistance with all Activities of Daily Living (ADLs) and was incontinent of bowel and bladder.</p> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 105531
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the resident's Care Plan, dated 4/19/25, revealed an ADL self-care performance deficit related to being bed bound, decreased mobility, multiple cardiac problems, morbid obesity, neuropathy, and chronic pain in conjunction with bowel and bladder incontinence.</p> <p>A review of the facility's Grievance Log from 4/1/25 through 4/21/25, revealed no record of a grievance filed by, or on behalf of, Resident #81.</p> <p>In an interview with the Social Services Director (SSD) on 4/24/25 at 11:45 AM, the SSD explained that if a resident or family had a concern/grievance, the person receiving the grievance should complete a grievance form. She explained that the grievance forms were available at the nurses' station and outside her office. She added that at times, the staff handed her the grievance form or slid it under her door during off hours. She added that at times when she was still in the building, the staff notified her right way when there was a concern, and she assisted in completing the grievance. After receiving the grievance, the concerns were reviewed during stand-up or stand-down meetings and assigned to the respective department to investigate. She further stated the grievances should be investigated within five days and the resident notified of the findings. She mentioned that some grievances may be extended more than five days; however, the resident should be kept abreast of the progress. After grievances were closed, she also followed up with the resident to ensure they were satisfied. Grievance reports were sent to the Administrator monthly. When asked if she had recent grievances from, or on behalf of Resident #81, she stated the last grievance was about a month ago and it was resolved. She reviewed the grievance log and confirmed there were no grievances from Resident #81 in April 2025. She was notified that the resident had care concerns and was asked to visit the resident and provide feedback to the surveyor.</p> <p>In a follow-up interview with the SSD on 4/24/25 at 1:36 PM, she stated she followed up with Resident #81 and the resident said that on the night of 4/15/25, she turned her call light on at approximately 1:00 AM, because she had a bowel movement (BM). A certified nursing assistant (CNA) came in at approximately 4:00 AM and stated she wasn't going to finish cleaning her because she still had BM in her rectum. Resident #81 stated she screamed until a nurse came and cleaned her. The resident stated she did not want that CNA caring for her anymore. She couldn't remember the CNA's name, but she notified the SSA the following morning during the guardian angel visit. The SSD confirmed that the grievance should have been filed for the resident. She added that she had notified the facility's Administrator and an investigation was initiated.</p> <p>During interview with the facility's Administrator on 4/24/25 at 1:51 PM, she stated the person receiving a grievance should complete a grievance form or assist the resident in completing it. She stated the goal was to have all grievances resolved within five days. Grievances were discussed daily in the morning and evening meetings. During off hours, staff should slide the grievance report under the SSD's door. When asked about the grievance related to Resident #18, she said, I was just informed of the issue with the resident by [the SSD]. I called [the SSA] regarding the incident and asked what happened. She said the CNA took too long to clean the resident (could not recall the timeframe), and did not clean the resident well enough until the nurse cleaned her. She confirmed that the staff did not follow the facility's grievance policy.</p> <p>A review of the facility's policy and procedure titled Complaint/Grievance, Document Name: N-1042 (revised on 10/24/2022), revealed:</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Policy: The Center will support each resident's right to voice a complaint/grievance without fear of discrimination or reprisal. The center will make prompt efforts to resolve the complaint/grievance and inform the resident of progress towards resolution. Grievances will be reviewed by the Quality Assurance Performance Improvement Committee. Grievances discovered to meet the definition of Abuse, Neglect, Exploitation or Misappropriation will be handled per the facility's Abuse Policy. The resident should have reasonable expectations of care and services and the center should address those expectations in a timely, reasonable, and consistent manner. The Center will inform residents of the right to file a grievance orally and in writing, the right to file grievances anonymously, the contact information of the Grievance Officer, a reasonable time frame for completing the review of the grievance, the right to obtain a written decision regarding the grievance, and contact information of independent entities with whom grievances may be filed (State agency, Ombudsman, Quality Improvement Organizations).</p> <p>Procedure :</p> <ol style="list-style-type: none"> <li>1. An employee receiving a complaint/grievance from a resident, family member, and/or visitor will initiate a Complaint/Grievance form. Complaint/Grievance forms will be available 24 hours per day, seven days a week in an unsecured common area. Accommodations will be made to ensure residents have the opportunity regardless of their physical abilities or limitations.</li> <li>2. Original grievance forms are then submitted to the Grievance Officer/designee for further action.</li> <li>3. The Grievance Officer shall act on the grievance and begin follow-up of the concern or submit it to the appropriate department director for follow-up.</li> <li>4. The grievance follow-up should be completed in a reasonable time frame not exceeding 14 days.</li> <li>5. The findings of the grievance shall be recorded on the Complaint/Grievance form.</li> <li>6. The result will be forwarded to the Executive Director for review and filing.</li> <li>7. The grievance official will log complaints/grievances in the monthly grievance log.</li> <li>8. The individual voicing the grievance will receive follow up communication with the resolution, and a copy of the grievance resolution will be provided to the resident upon request.</li> </ol>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30905</p> <p>Based on record review, staff interview, and facility policy and procedure review, the facility failed to ensure that residents with mental disorders were appropriately assessed on admission, or as needed, to determine the need for specialized services for five (Residents #32, #26, #50, #65 and #22) of five residents reviewed for Preadmission Screening and Resident Review (PASRR). Resident #32 was declared exempt from the PASRR upon admission for a period not to exceed 30 days and was not screened when the provisional admission ended. Resident #26's PASRR section I was incomplete and Section II was answered in the affirmative. Resident's #50's PASRR section I was incomplete and Resident #65's PASRR indicated that she had a Hospital Discharge exemption. Resident #22's Level I PASRR was not signed.</p> <p>The findings include:</p> <p>1. A review of Resident #32's medical record revealed an admitted [DATE]. His diagnoses included hydrocephalus, polyneuropathies, seizures, major depression, bipolar disorder, insomnia, presence of cerebrospinal fluid drainage device, atherosclerotic heart disease, hypothyroidism, unspecified psychosis, anxiety disorder, and respiratory failure - unspecified with hypoxia or hypercapnia.</p> <p>A review of the State of Florida Agency for Health Care Administration Preadmission Screening and Resident Review (PASRR) Level I Screening form 004 Part A, dated 07/22/2022, revealed that the box indicating the admission was a Provisional Admission was checked. No other PASRR screening was found in the medical record.</p> <p>During an interview with the Regional Nurse Consultant (RNC) on 04/24/2025 at 5:33 PM, he confirmed that Resident #32 had not been screened after the 30-day provisional admission ended. He stated the resident should have been screened again.</p> <p>42442</p> <p>2. A review of the medical record revealed that Resident #26 was admitted to the facility on [DATE] with a re-entry on 3/31/24. The resident's diagnoses included major depressive disorder, generalized anxiety disorder, alcohol abuse with alcohol induced psychotic disorder, and manic episode without psychotic symptoms.</p> <p>A review of the Level I PASRR, dated 8/3/15, revealed no diagnoses marked under Section I. In Section II: Other Indications for PASRR Screen Decision-Making, the following areas were marked as Yes:</p> <p>1. Is there an indication within the past 3 to 6 months that the individual has a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for the individual's developmental stage?</p> <p>2. Does the individual typically have at least one of the following characteristics on a continuing or intermittent basis?</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A. Interpersonal functioning: The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, fear of strangers, avoidance of interpersonal relationships, social isolation, or has been fired.</p> <p>B. Concentration, persistence, and pace: The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks.</p> <p>C. Adaptation to change: The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.</p> <p>3. The individual has received recent treatment for a mental illness with an indication that the individual has experienced at least one of the following.</p> <p>A. Psychiatric treatment more intensive than outpatient care. (Copy obtained)</p> <p>3. A review of the medical record revealed that Resident #65 was admitted to the facility on [DATE] with a re-entry on 3/2/25 and diagnoses including schizoaffective disorder, bipolar disorder, major depressive disorder, generalized anxiety disorder, and manic episode severe with psychotic symptoms.</p> <p>The care plan initiated on 2/7/25 revealed that the resident had diagnoses including schizoaffective disorder, bipolar disorder, depression, generalized anxiety disorder with a history of in-patient psychiatric treatment for aggressive and violent behaviors; a history of making false accusations against others with delusional symptoms; occasions of auditory hallucinations, and a history of post-traumatic stress disorder (PTSD) with a history of traumatic experiences as a child.</p> <p>A review of the resident's PASRR Level I, dated 1/27/25, revealed that the resident had a diagnosis of schizophrenia. In Section II, Other Indications for PASRR Screen Decision-Making, the following areas were marked as Yes:</p> <p>3. Individual has received recent treatment for a mental illness with an indication that the individual has experienced at least one of the following:</p> <p>A. Psychiatric treatment more intensive than outpatient care.</p> <p>B. Due to the mental illness the individual has experienced an episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home or in a residential treatment environment or which resulted in intervention by housing or law enforcement officials.</p> <p>4. Individual exhibited actions of behaviors that may make them a danger to themselves or others.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Under Section III, PASRR screen provisional or Hospital discharge exemption, noted that the resident was being admitted under a 30-day Hospital Discharge exemption. If the individual's stay is anticipated to exceed 30 days, the nursing home must notify the Level I screener at the 25th day of stay, and the level II evaluation must be completed no later than the 40th day after admission. The form also indicated that the individual may not be admitted to the nursing facility. (Use this form as required documentation to request a Level II PASRR evaluation because there is a diagnosis of or suspicion of serious mental illness.) (Copy obtained)</p> <p>4. Resident #50 was admitted to the facility on [DATE] with a re-entry on 10/21/23 and diagnoses including paranoid schizophrenia, pseudobulbar affect (a neurological condition characterized by sudden, uncontrollable episodes of laughing or crying that are often inappropriate or out of proportion to the situation or the person's actual feelings), major depressive disorder, generalized anxiety disorder, restlessness and agitation.</p> <p>A review of the active physician's orders revealed:</p> <p>Nuedexta (central nervous systme agent) capsule 20 -10 mg (milligrams) every 12 hours related to pseudobulbar affect - order date 5/1/24.</p> <p>Haloperidol (antipsychotic) 100 mg/ml (milligrams per milliliter), inject 100 mg intramuscularly (IM) every 14 days for schizophrenia - order date 8/24/24.</p> <p>Depakote (anticonvulsant that can be used to treat bipolar disorder) 500 mg three times a day for mood disorder.</p> <p>Primidone (anticonvulsant) 50 mg at bedtime for essential tremors - order date 1/2/25.</p> <p>Trazadone (antidepressant and sedative) 50 mg two times a day (BID) for major depressive disorder - order date 3/6/25.</p> <p>A review of the Care Plan revealed a target completion date of 5/7/25 and indicated that Resident #50 was known to be physically aggressive as evidenced by kicking other residents related to paranoid schizophrenia and being developmentally delayed. She had impaired cognitive function and impaired thought processes related to developmental delay and paranoid schizophrenia. The care plan further noted that the resident was receiving antipsychotic therapy related to a diagnosis of mood disorder, paranoid schizophrenia, and mania. She was receiving an anticonvulsant medication for diagnoses of paranoid schizophrenia and mood disorder.</p> <p>A review of the Quarterly minimum data set (MDS) assessment with an Assessment Reference Date (ARD) of 1/15/25 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 03 out of 15 possible points, indicating severe cognitive impairment. Active psychiatric diagnoses included schizophrenia, depression, and anxiety.</p> <p>A review of the Level I PASRR dated 6/2/21 revealed no diagnoses of schizophrenia, major depressive disorder, depression, or anxiety disorder documented.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 4/24/25 at 4:16 PM, the Social Services Director (SSD) stated she was responsible for ensuring that all PASRRs were completed on admission and as needed. She identified that some PASRRs were incomplete and/or inappropriately completed by the previous SSD. She stated she developed a plan to review five PASRRs weekly and was still in the process of reviewing them. She confirmed that she had reviewed the PASRR for all of the residents requested by the survey team, and they were incomplete and/or required a Level II screening.</p> <p>45153</p> <p>5. A review of Resident #22's Level 1 PASRR revealed no physician's signature and no date.</p> <p>A record review was conducted for Resident #22 noting an admitted [DATE] with an initial admission on 12/14/17. His diagnoses included schizophrenia, anxiety disorder, major depressive disorder, and insomnia due to other mental disorder.</p> <p>A review of Resident #22's active physician's orders revealed the following:</p> <p>Ativan (benzodiazepine/sedative) Oral Tablet 1 mg, give 1 tablet by mouth every 24 hours as needed for behaviors sleep aid per outside psychology (4/22/2025)</p> <p>Ativan Oral Tablet 1 mg, give 1 tablet by mouth every 8 hours as needed for increased behaviors for 14 days (4/22/2025)</p> <p>Buspirone HCL (hydrochloride) (anxiolytic) Tablet, 30 mg, give 30 mg by mouth two times a day related to anxiety disorder due to known physiological conditions (5/25/2024)</p> <p>Haloperidol Tablet (antipsychotic), 10 mg, give 2 tablets by mouth at bedtime related to schizophrenia, unspecified (5/25/2024)</p> <p>Melatonin Tablet (sleep supplement), 3 mg, give 2 tablets by mouth at bedtime related to insomnia due to other mental disorder (5/25/2024)</p> <p>Quetiapine Fumarate (antipsychotic) Tablet, 300 mg, give 2 tablets by mouth at bedtime related to schizophrenia, unspecified (5/25/2024)</p> <p>Trazodone HCL (antidepressant and sedative) Tablet, 150 mg, give 2 tablets by mouth at bedtime for depression, recurrent (5/25/2025).</p> <p>A review of the April 2025 Medication Administration Record (MAR) revealed that the abovementioned medications were provided as ordered.</p> <p>A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident re-entered from a short-term hospital stay with a Brief Interview for Mental status (BIMS) score of 8 out of 15 possible points, indicating moderate cognitive impairment.</p> <p>On 4/24/25 at 2:02 PM, the Regional Nurse Consultant was asked to provide a copy of Resident #22's signed PASRR.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/24/25 at 2:10 PM, a Level 1 PASRR for Resident #22 was received with no physician's signature and no date.</p> <p>A review of the facility's Policy and Procedure titled Preadmission Screening and Resident Review (PASRR) - Document Name: SS-402, Revision Date: 11/08/21 revealed:</p> <p>Policy: The center will assure that all Serious Mentally Ill (SMI) and Intellectually Disabled (ID) residents receive appropriate pre-admission screenings according to Federal/State guidelines. The purpose is to ensure that the residents with SMI or are ID receive the care and services they need in the most appropriate setting.</p> <ol style="list-style-type: none"> <li>1. It is the responsibility of the center to assess and assure that the appropriate preadmission screenings, either Level I or Level II, are conducted and results obtained prior to admission and placed in the appropriate section of the resident's medical record.</li> <li>2. If an individual is declared exempt from a PASRR screening, the center should make sure that appropriate documentation is in the chart upon admission. Individuals who are exempt from this assessment include:             <ol style="list-style-type: none"> <li>a. Those who are admitted after a release from an acute care hospital for a period not to exceed 30 days as part of a medically prescribed period of recovery.</li> <li>b. Those who are certified by a physician as to be terminally ill with a 6-month prognosis, and are not a danger to self or others.</li> <li>c. Those who are comatose, ventilator dependent, functions at significantly disabling Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis, CHF or COPD. d. Those with a diagnosis of dementia or its related disorders with detailed documentation supporting this diagnosis.</li> </ol> </li> <li>3. There are no exceptions for Intellectually Disabled (ID) screenings.</li> <li>4. If it is learned after admission that a PASRR Level II screening is indicated, it will be the responsibility of Social Services to coordinate and/or inform the appropriate agency to conduct the screening and obtain the results.</li> <li>5. Results of the screening evaluation will be placed in the appropriate section of the individual's medical record and any recommendations for services will be followed.</li> <li>6. Recommendations will be incorporated in the individual resident's plan of care and approaches/interventions developed to meet the identified needs of the individual.</li> <li>7. Social Services will be responsible for coordinating significant change updates of these screenings, conducted by the appropriate agency. These results, along with the results from the previous years will be kept in the appropriate sections of the resident's records.</li> </ol> <p>Reference: [NAME] Health Care Consulting Services, Inc.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48947</p> <p>Based on observations, interviews, record reviews, and facility policy and procedure review, the facility failed to ensure the residents' environment was as free as possible from hazards for two (Residents #23 and #59) of 38 residents in the total survey sample.</p> <p>The findings include:</p> <p>1. On 4/21/25 at 11:10 AM, an observation was made of medications (pills) in a medication cup on the bedside table and a jar of medication on the nightstand at Resident #23's bedside. (Photographic evidence obtained).</p> <p>On 4/22/25 at 11:24 AM, an observation was made of medications in a medicine cup and also on the bedside table and night stand at Resident #23's bedside. (Photographic evidence obtained)</p> <p>On 4/22/25 at 11:25 AM an interview was conducted with Resident #23. When asked whether the nurse brought him his medication, he stated, No, I go to the cart and get it because I was getting my medications late, so I go get them. He was asked if he took his medications in front of the nurse or brought them back to his room to take them. He stated, I take my narcotics right there in front of the nurse. When he was asked how long the observed medication had been sitting on his table/nightstand, he replied, The nurse gave it to me this morning. (referring to the pills in the medicine cup). This is my potassium and I take this after I eat lunch so it won't upset my stomach. When asked about the remaining medications spilled on the table/nightstand, he stated, Those were given to me on another day and I didn't need them. Those are to make my bowels move or make them slow down.</p> <p>A record review revealed that Resident #23 was admitted to the facility on [DATE] with diagnoses including atherosclerotic heart disease, other specified polyneuropathies, diabetes mellitus, type 2, low back pain, anxiety disorder, other chronic pain, insomnia, alcohol abuse, pin in left hip, pain in right leg, peripheral vascular disease, polysubstance abuse, ADHD (attention deficit hyperactive disorder), and depression/mood disorder.</p> <p>A review of the Annual MDS (minimum data set) assessment, dated 2/21/25, revealed a BIMS (brief interview for mental status) score of 13 out of 15 possible points, indicating intact cognition. The assessment revealed the resident had no behaviors, required setup or clean-up assistance with eating, and was independent with toileting, bed mobility and transfer tasks. It also indicated the presence of pain that occasionally interfered with day-to-day activities, on numerical pain scale at 07/10.</p> <p>A review of the Care Plan revealed the following focus areas:</p> <p>- Alteration in usual functional performance in self-care related to weakness, debility, neuropathy (created 2/24/25, revised 3/12/25)</p> <p>- ADL (activities of daily living) self-care performance deficit related to unsteady gait, balance, neuropathic pain, chronic pain, (CAD) Coronary Artery Disease, muscle spasms. I will refuse showers/bathing (created 3/29/23, revised 3/13/25).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Aviata at San Jose		STREET ADDRESS, CITY, STATE, ZIP CODE  9355 San Jose Blvd Jacksonville, FL 32257	

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- I am receiving an over-the-counter sleep aid related to insomnia (created 3/29/23, revised 3/13/25).</p> <p>- I am receiving an antidepressant for a diagnosis of depression (created 3/29/23, revised 3/13/25).</p> <p>- I am receiving an anti-anxiety for a diagnosis of anxiety disorder (created 3/29/23, revised 3/13/25).</p> <p>- I am receiving diuretic therapy related to hypertension (created 2/24/25, revised 3/13/25).</p> <p>- I have acute, chronic pain related to a diagnosis of low back pain, chronic pain, muscle spasms, neuropathic pain, degenerative joint disease (created 3/29/23, revised 3/13/25).</p> <p>Further review of the record revealed no care plan to direct care for the resident to self-administer medications.</p> <p>A review of the active physician's orders revealed the following:</p> <p>Alprazolam (sedative) 0.5 mg (milligrams) by mouth twice daily for anxiety (5/26/24)</p> <p>Torsemide (diuretic) 20 mg by mouth daily for edema (6/28/24)</p> <p>Methadone (narcotic) 10 mg, give 4 tablets by mouth daily (9/25/24)</p> <p>Trazadone (antidepressant and sedative) 100 mg by mouth at bedtime for major depressive disorder, insomnia (2/13/25)</p> <p>Percocet (narcotic) 5-325 mg by mouth every 4 hours as needed for joint pain (3/14/25)</p> <p>Non-pharmacological interventions use every shift (9/30/24)</p> <p>Assess for pain every shift (5/26/24)</p> <p>Behavior monitoring every shift (5/26/24)</p> <p>Side effects monitoring every shift (5/26/24)</p> <p>No physician's order was found permitting the resident to self-administer medications.</p> <p>A review of the psychiatric progress notes revealed that the resident was followed monthly and as needed for depression, anxiety, insomnia and alcohol abuse.</p> <p>Further review of the record revealed no assessment for self-administration of medications.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/22/25 at 11:39 AM an interview was conducted with Licensed Practical Nurse (LPN) A. When she was asked to describe the responsibilities of the nurse who was administering medications to a resident, she stated, The nurse is responsible to make sure that the resident has an adequate amount of water, that they swallow all the medication, that all medications are given with the correct dose, the correct medication, the correct frequency, and that all medications have a doctor's order. With inhalers, we make sure they get the correct dose, monitor them to make sure they don't have an adverse reaction, and they have the right to refuse medications. When she was asked if it was appropriate for medications to be stored at the resident's bedside, she replied, Well, it depends on what the medication is and if the resident has a doctor's order and the consents for self-administration of medications. If they can self-administer, we still have to monitor how they store it or whether it needs to be stored on the medication carts and also monitor for the expiration dates, and add it to the care plan. The nurse was accompanied to the resident's bedside and she confirmed that there was a medication cup with two pills in it and five additional, various pills on the bedside table. The nurse confirmed that one of the pills was the resident's potassium that had been administered on 4/22/25 (9:00 AM dose). She asked the resident's permission to remove all of the medications and he gave her permission.</p> <p>On 4/22/25 at 4:35 PM, a brief interview was conducted with LPN B. When she was asked what the facility's process was for residents self-administering medications, she stated, We get an order from the physician. She was asked if there were any residents currently in the facility who self-administered medications. She replied that she didn't think there were any residents who did.</p> <p>When she was asked what the nurse's responsibility was when administering medications to residents, she replied, The nurse's responsibility is to make sure the resident takes the meds and swallows them.</p> <p>On 4/23/25 at 11:37 AM, an interview was conducted with Certified Nursing Assistant (CNA) E, who was asked what she did if she found medications in a resident's room. She stated, I would ask the resident how long the medications had been there and let the nurse know that the resident still has it and hasn't taken it. When asked how often she saw medications in residents' rooms, she replied, Not often. She was asked if she knew whether or not there were residents in the facility who were able to self-administer their own medications, she replied, No, it's supervised.</p> <p>A review of the facility's policy and procedure titled Monthly Drug Regimen Review (N-866, effective: 04/21/2017, revised 3/28/2024), revealed:</p> <p>Procedure: To ensure the requirement is met for monthly drug regimen review the ED/DON (Executive Director/Director of Nursing) should implement the following process:</p> <p>Downloading of Pharmacist Consultant Report: Available from contracted pharmacy via secure email or database</p> <p>- Day 15-21 the DON/designee will contact the physicians with any outstanding recommendations. If no response from the physician, the facility may notify the Medical Director for further assistance.</p> <p>Consultant Report - Continuous Print</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This report is to be used by the DON/designee to record responses returned from the physician and for follow-up on any outstanding recommendations.</p> <p>If follow-up for the consultant pharmacist recommendations is not completed within the specified time frame, this should be reported to the Medical Director for follow up with attending physician as indicated.</p> <p>A review of the facility's policy and procedure titled Medication - Oral Administration (N-853, effective 11/30/2014, revision 8/15/2019), revealed:</p> <p>Procedure:</p> <p>Review physician's order.</p> <p>Document the administration and acceptance or decline of all medications administered.</p> <p>a. Should the resident decline or be unable to accept the medication, this will need to be documented following standard protocol.</p> <p>2. On 4/21/25 at 11:29 AM, an observation was made of several razors in a plastic bag on the resident's dresser. (Photographic evidence obtained)</p> <p>A record review for Resident #59 revealed an admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia, COPD (Chronic Obstructive Pulmonary Disease), dependence on supplemental oxygen, unspecified diastolic congestive heart failure, bipolar disorder, major depressive disorder, and generalized anxiety.</p> <p>A review of the Annual MDS (minimum data set) assessment, dated 2/6/25, revealed a BIMS (brief interview for mental status) score of 6 out of 15 possible points, indicating severe cognitive impairment. The resident required partial/moderate assistance with eating, bed mobility and toileting, and was dependent for transfers. The assessment also indicated that the resident received anticoagulants.</p> <p>A review of the resident's Care Plan revealed the following focus areas:</p> <p>I have an ADL (activities of daily living) self-care performance deficit related to unsteady balance/gait, impaired vision, COPD/asthma, oxygen dependent (created 3/21/22, revised 12/12/24).</p> <p>I have impaired cognitive function (created 3/16/23, revised 1/10/25).</p> <p>I am receiving anticoagulant therapy prophylaxis (created 1/10/25, revised 1/10/25).</p> <p>I am receiving oxygen therapy. I will remove my oxygen. I will become SOB (short of breath) when lying flat. Wheezing noted. (created 10/12/2022, revised 1/10/25).</p> <p>I have a diagnosis of asthma/COPD. Risk for impaired gas exchange. I will become SOB while lying flat. Oxygen for SOB, nodule at right lung base. (created 3/21/2022, revised 1/10/25).</p> <p>A review of the active physician's orders revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Pulmicort Inhalation Suspension 0.5 mg/2ml (milligrams per milliliter), Inhale orally twice daily related to COPD (1/9/25)</p> <p>Apixaban 5 mg by mouth, give 2 tablets twice daily for DVT (deep vein thrombosis) 7 days and give 1 tablet by mouth twice daily for DVT PPX (prophylaxis)(1/9/25)</p> <p>Brovana Inhalation Nebulization Solution 15 mcg/ml (micrograms per milliliter), 2 ml inhale orally for COPD (1/9/25)</p> <p>Respiratory oxygen-continuous 4 liters via nasal cannula every shift for SOB (1/9/25)</p> <p>Pulse oximetry every day shift for monitoring (1/10/25)</p> <p>Head of bed elevated to alleviate SOB every shift related to COPD (2/13/25)</p> <p>On 4/23/25 at 11:37 AM, an interview was conducted with CNA E, who was asked if the facility staff provided razors or shaving materials to the residents. She stated, Yes, if the resident is safe with sharp objects, but personally, I still supervise my residents when they shave. She was asked how the facility stored razors. She replied, Razors are stored in the supply closets on the units.</p> <p>When asked if razors were supposed to be stored in resident rooms, she replied, No, they can ask the staff for them and we supply the razors. When asked if resident rooms were kept neat and tidy, she replied yes. When she was asked how often she cleaned the residents' areas, she replied, I make the bed, declutter the bedside table so it has room on it for the meal tray, and declutter the pathways to keep them safe.</p> <p>On 4/24/25 at 12:36 PM, an interview was conducted with LPN K, who was asked to describe some things she did to make the resident's environment safe. She stated, Make sure the call light is in reach, answer call lights quickly, rounding, signs up for oxygen, signage for any isolation precautions so everyone's aware, no fans because they can start a fire, and no rugs because they are a fall hazard. When asked if the facility staff provided razors or shaving materials to the residents, she replied, yes. When asked how the facility stored razors, she said, Locked in the clean linen closet. When asked if razors could be stored in resident rooms, she replied, I'll have to get back to you on that because I haven't really seen razors in resident rooms. When she was asked what she should do if she observed razors in a resident's room, she stated, I would probably confirm whether they are supposed to have it or not before I just remove it.</p> <p>A review of the facility's policy and procedure titled Safety Precautions-General (S-360, effective date: 11/30/2014, 2 pages), revealed:</p> <p>Policy: General safety rules will be followed by all personnel to prevent injury of employees, residents, and visitors.</p> <p>Sharps Disposal</p> <p>Policy Statement:</p> <p>The facility shall discard contaminated sharps into designated containers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Policy Interpretation and Implementation</p> <p>1. Whoever uses contaminated sharps will discard them immediately or as soon as feasible into designated containers.</p> <p>On 4/24/25 at 5:49 PM, Registered Nurse (RN) D was asked to provide a policy that pertained to safe handling/storage of razors. No policy was provided during the survey.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48947</p> <p>Based on observations, interviews, record review, and facility policy and procedures review, the facility failed to provide enteral nutrition per the physician's order for one (Resident #100) of two residents reviewed for enteral nutrition, from a total of seven residents receiving enteral nutrition.</p> <p>The findings include:</p> <p>On 4/21/25 at 11:35 AM, enteral nutrition administration was observed in progress for Resident #100 via pump at 40 ml/hour (milliliters per hour). (Photographic evidence obtained) There was no resident identifier on the nutrition bottle. The nutrition bottle was labeled incorrectly (40 ml/hour). A record review revealed the resident had a physician's order for Jevity 1.5 at 45 ml/hour for 20 hours, on at 2:00 PM, off at 10:00 AM the next day - ordered 4/15/25, and two times a day water flush: 200 ml 2x/day for 400 ml for hydration, ordered 4/14/2025.</p> <p>On 4/22/25 at 11:58 AM, enteral nutrition administration was observed in progress for Resident #100 via pump at 40 ml/hour. (Photographic evidence obtained)</p> <p>A review of the medical record revealed that Resident #100 was admitted to the facility on [DATE] with diagnoses including unspecified severe protein-calorie malnutrition, adult failure to thrive, and feeding difficulties, unspecified.</p> <p>A review of the Admission MDS (minimum data set) assessment, dated 3/20/25, revealed that the resident had a BIMS (brief interview for mental status) score of 14 out of 15 possible points, indicating intact cognition. She was noted as dependent for eating, toileting and transfer tasks, and required substantial/maximal assistance with bed mobility. Her weight was recorded as 83 pounds and her height was 64 inches.</p> <p>A review of the active physician's orders revealed the following:</p> <p>Enteral: Check residual every shift and notify medical doctor for greater than 120 ml (milliliters) (3/19/25)</p> <p>Change feeding set per manufacturer's guidelines (3/19/25)</p> <p>Change tubing and syringe daily every night shift (3/19/25)</p> <p>Stoma care every night shift (3/19/25)</p> <p>Change the enteral feeding bottle per manufacturer's guidelines (3/19/25)</p> <p>Enhanced barrier precautions related to gastrostomy tube and Foley (urinary catheter) (3/20/25)</p> <p>Tube feeding - Check for placement every shift (3/19/25)</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Enteral feeding two times a day for tube feeding order Jevity 1.5 @ 45 ml (milliliters) for 20 hours on at 2:00 PM, off at 10:00 AM or until TV (total volume) is infused (TV - 900 ml) (4/22/25)</p> <p>Regular diet, dysphagia pureed texture, regular/thin liquids consistency (3/15/25)</p> <p>A review of the resident's Care Plan revealed the following focus area:</p> <p>I am receiving enteral feedings via enteral feeding tube due to dysphagia. I am also receiving by mouth diet. I am at risk for complications. Goal: I will maintain adequate nutritional and hydration status as evidenced by weight stable, no signs or symptoms of malnutrition or dehydration through next review date. Intervention: The resident is dependent with tube feeding and water flushes. See medical doctor orders for current feeding orders. [LPN] (licensed practical nurse), [RN] (Registered Nurse) (created 4/8/25, revised 4/8/25)</p> <p>On 4/23/25 at 11:37 AM, an interview was conducted with Certified Nursing Assistant (CNS) E, who was asked what her role was in taking care of a resident with a gastrostomy tube for enteral nutrition. She replied, When I give them a bath, I get the nurse to come and disconnect the feeding, let their head down, give the care, let their head back up and get the nurse to come and turn it back on. She stated there was never a time when she, the CNA, adjusted the feeding pump.</p> <p>On 4/23/25 at 2:40 PM, an interview was conducted with the Director of Nursing (DON), who was asked to explain the facility's process/protocol for the administration of enteral nutrition. She stated, I will need to review the policy. She was asked what the facility's policy was for what was required to be written on the enteral nutrition - what identifiers. She stated, The resident's name, the room number, the time you hang the bottle, the flow rate, and the flush rate.</p> <p>On 4/24/25 at 11:19 AM, an interview was conducted with Licensed Practical Nurse (LPN) L, who stated today she was responsible for the residents on the 200 and 300 hallways. She reviewed the electronic medical record daily to review changes with residents along with receiving report from the off-going nurse. She reported changes in conditions to the Medical Director and DON as needed to get additional treatment information. When she was asked about residents receiving enteral nutrition, she reported that she confirmed the physician's order in the resident's chart; she explained how to check for appropriate placement (she aspirates, and if she feels the tubing is dislodged, she will stop, inform the provider and ask for an x-ray to confirm or deny her suspicion).</p> <p>A review of the facility's policy and procedure titled Enteral Feeding - Enteral Nutrition Pump (N-405, effective 11/30/2014, revised 11/12/2018), revealed:</p> <p>Policy:</p> <p>Nurses administer enteral feedings when volume control is indicated and as ordered by the physician.</p> <p>Procedure:</p> <p>Obtain a physician's order.</p> <p>Follow pump manufacturer's guidelines. Set pump to physician's orders.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48947</b></p> <p>Based on observations, interviews, record review, and facility policy and procedure review, the facility failed to provide oxygen therapy per the physicians' orders for two (Residents #24 and #59) of three residents reviewed for respiratory care, from a total survey sample of 38 residents.</p> <p>The findings include:</p> <p>1. On 4/21/25 at 11:52 AM, while visiting the resident in his room, oxygen was observed infusing at 3.5 L/min (liters per minute) via NC (nasal cannula). (Photographic evidence obtained). The resident was asked if he knew what his oxygen flow rate should be. He replied, It should be all the way up. I need all I can get.</p> <p>On 4/22/25 at 12:49 PM, while visiting the resident in his room, oxygen was observed infusing at 3.5 L/min via NC. (Photographic evidence obtained) The resident stated, It's a little cooler in here today, but I'm still hot and I really don't feel like talking.</p> <p>A review of Resident #24's medical record revealed an admitted [DATE] and diagnoses including polyneuropathies, PVD (Peripheral Vascular Disease), morbid obesity, dysthymic disorder, tobacco use, bipolar disorder, major depressive disorder, generalized anxiety disorder, insomnia, iron deficiency anemia (chronic), COPD (Chronic Obstructive Pulmonary Disease), and diabetes mellitus (DM).</p> <p>A review of the Annual MDS (minimum data set) assessment, dated 3/14/25, revealed that the resident had a BIMS (brief interview for mental status) score of 15 out of 15 possible points, indicating intact cognition. He required partial/moderate assistance with bed mobility; supervision or touching assistance with toileting, and he refused transfer tasks and was independent with eating.</p> <p>A review of the active physician's orders revealed the following orders:</p> <ul style="list-style-type: none"> <li>- Respiratory: Oxygen - Continuous at 5 liters via nasal cannula for shortness of breath (SOB) every shift (5/25/24)</li> <li>- Change tubing, mask and/or nasal cannula weekly on Sunday night; may change sooner as needed (5/25/24)</li> <li>- Pulse Oximeter every shift for monitoring, Albuterol Sulfate Inhalation Nebulization Solution. 3 ml (milliliters), inhale orally via nebulizer every 6 hours as needed for shortness of breath. Check lung sounds, heart rate and respirations pre- and post-nebulizer treatment. Record minutes of nebulizer treatments (1/6/25)</li> <li>- Breztri Aerosphere Inhalation Aerosol 160-9-4.8 mcg/act (micrograms per actuation), 2 puffs inhale orally every 12 hours as needed for shortness of breath (2/24/25).</li> </ul> <p>A review of the Care Plan revealed the following focus area:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- I have a diagnosis of COPD. I will become short of breath while lying flat and on exertion. Oxygen in use for shortness of breath. Goal: I will display optimal breathing patterns daily through review date. Interventions: Avoid extremes of hot and cold, monitor oxygen saturation as ordered, administer oxygen as ordered. (created 5/24/21, revised 1/13/25).</p> <p>On 4/22/25 at 4:35 PM, an interview was conducted with Licensed Practical Nurse (LPN) B, who was asked if she had been provided training/education about how to administer oxygen. She replied, Yes. She explained the steps for oxygen administration as: Get the oxygen concentrator, get the cannula, set the concentrator flow rate, and apply the cannula. She was asked how often the nurse was required to check the resident's oxygen flow rate. She replied, Every time she comes in the room.</p> <p>On 4/23/25 at 11:37 AM, an interview was conducted with Certified Nursing Assistant (CNA) E, who was asked to define her role in taking care of a resident who was receiving oxygen therapy. She stated, As far as oxygen, it's considered a medication, so the only thing I do is check to see if it's running, or if it's full and make sure it's in their nose. The nurse takes care of the oxygen itself.</p> <p>On 4/23/25 at 2:40 PM, an interview was conducted with the Director of Nursing (DON), who was asked what the facility's policy was for humidification of oxygen. She replied, I will need to review the policy and get back to you on that. She was asked what the facility's process was for ensuring that residents' supplemental oxygen was infusing at the ordered flow rate. She replied, I will need to review the policy and get back to you. When asked how often nursing staff were required to check residents' oxygen flow rates, she replied, I will need to review the policy and follow up with you on that.</p> <p>As of 4/24/25 at 5:50 PM (conclusion of the survey), the DON had not provided any responses to the abovementioned interview questions.</p> <p>2. On 4/21/25 at 11:29 AM, while visiting the resident in his room, oxygen was observed infusing at 3 L/min (liters per minute) via nasal cannula (NC). No oxygen signage was observed on the resident's door. (Photographic evidence obtained)</p> <p>On 4/22/25 at 12:43 PM, while visiting the resident in his room, oxygen was observed infusing at 3 L/min (liters per minute) via nasal cannula (NC). (Photographic evidence obtained)</p> <p>A review of Resident #59's medical record revealed an admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia, COPD, dependence on supplemental oxygen, unspecified diastolic congestive heart failure, bipolar disorder, major depressive disorder, and generalized anxiety.</p> <p>A review of the active physician's orders revealed the following orders:</p> <ul style="list-style-type: none"> <li>- Pulmicort Inhalation Suspension 0.5mg/2ml (milligrams per milliliters), Inhale orally twice daily related to COPD (1/9/25)</li> <li>- Brovana Inhalation Nebulization Solution 15 mcg/ml (micrograms per milliliter), 2 ml inhale orally for COPD (1/9/25)</li> <li>- Respiratory Oxygen-Continuous at 4 liters via nasal cannula every shift for SOB (shortness of breath)(1/9/25)</li> </ul> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- Pulse oximetry every day shift for monitoring (1/10/25)</li> <li>- Head of bed elevated to alleviate SOB every shift related to COPD (2/13/25).</li> </ul> <p>A review of the Annual MDS (minimum data set) assessment, dated 2/6/25, revealed that the resident had a BIMS (brief interview for mental status) score of 6 out of 15 possible points, indicating severe cognitive impairment. He required partial/moderate assistance with eating, toileting, bed mobility and was dependent for transfers.</p> <p>A review of the active Care Plan revealed the following focus areas:</p> <ul style="list-style-type: none"> <li>- I have an ADL (activities of daily living) self-care performance deficit related to unsteady balance/gait, impaired vision, COPD/asthma, and oxygen dependence (created 3/21/22, revised 12/12/24).</li> <li>- I have impaired cognitive function (created 3/16/23, revised 1/10/25).</li> <li>- I am receiving oxygen therapy. I will remove my oxygen. I will become SOB when lying flat. Wheezing noted. (created 10/12/2022, revised 1/10/25).</li> <li>- I have diagnosis of asthma/COPD. Risk for impaired gas exchange. I will become SOB (short of breath) while lying flat. Oxygen for SOB&gt; Nodule to right lung base. (created 3/21/2022, revised 1/10/25).</li> </ul> <p>A review of the facility's policy and procedure for Oxygen Therapy (RT-430, effective 110/30/2014, revised 8/28/2017), revealed:</p> <p>Policy: Oxygen therapy is the administration of a FiO2 (fraction of inspired oxygen) greater than 21% by means of various administration devices to:</p> <p>Raise the resident's PaO2 (the pressure of oxygen dissolved in the arterial blood) to an acceptable baseline using the lowest FiO2; to treat arterial hypoxemia; to decrease the work of breathing; to reverse and prevent tissue hypoxia, and/or; to decrease myocardial work.</p> <p>Equipment: NO SMOKING sign</p> <p>Procedure:</p> <p>Physician's order for oxygen therapy shall include: FiO2 or liter flow rate.</p> <p>Review physician's order.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42442</b></p> <p>Based on observations, interviews, and record review, the facility failed to ensure sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to attain/maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This affected two (Residents #63 and #81) of a total survey sample of 38 residents with the potential to affect more of the facility's population.</p> <p>The findings include:</p> <p>1. During the initial tour on 4/21/25 at 12:00 PM, Resident #63 was observed in bed wearing a hospital gown. His left arm was contracted. In an interview at 12:05 PM, Resident #63 stated someone came to his room at around 9:00 AM and placed the gloves in the gloves holder. He notified the staff person at that time (could not remember the name) that he wanted to get up. He said he had not seen anyone since then. He explained that he liked to get up after breakfast and get back in bed before dinner. He added that he did not get up the previous day despite asking staff several times. He said he preferred to get up daily.</p> <p>On 4/21/25 12:30 PM, Resident #63 was asked to activate the call light and notify staff that he would like to get up. The surveyor walked out of the resident's room and monitored the call light at the nurses' station.</p> <p>On 4/21/25 at 12:45 PM, the MDS (Minimum Data Set) Nurse responded to the call light. She notified the assigned nurse that Resident #63 was waiting for the Certified Nursing Assistant (CNA) to get him up. She stated she left the call light on per resident request.</p> <p>On 4/21/25 at 1:09 PM (with the call light still on and the resident wearing a hospital gown), a follow-up interview was conducted with Resident #63. He confirmed that he had asked three staff members to get up since 9:00 AM and none had attended to his needs. That was why he asked to have the call light left on until his needs were met.</p> <p>On 4/21/25 at 1:30 PM, the Assistant Director of Nursing (ADON) from the sister facility turned off Resident #63's call light.</p> <p>On 4/21/25 at 1:35 PM, a follow-up interview was conducted with Resident #63. He was having lunch at the time and was still wearing the hospital gown. He stated the call light was switched off because he was notified that his assigned CNA was in the dining room. He said, I am afraid that the light was turned off because when the staff comes back, she/he will not know that I need assistance. He activated the call light again.</p> <p>On 4/21/25 at 1:45 PM, the Administrator went to the resident's room and turned off the call light.</p> <p>During another follow-up interview on 4/21/25 at 1:50 PM, Resident #63 stated the Administrator had turned off the call light stating she was going to get someone to assist him.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/21/25 at 2:00 PM, Licensed Practical Nurse (LPN) F/Unit Manager was asked about Resident #63. She stated she worked on a different nursing unit and was moved to the current unit today, therefore she was not familiar with most of the residents. She was asked to accompany the surveyor to Resident #63's room. Resident #63 was observed in bed still in a hospital gown. He was asked to state his concerns to LPN F. He stated he had been asking to get up since 9:00 AM after breakfast and no one had assisted him yet. She asked the resident for his preferred time to get up. He responded, At 10:00 AM and back in bed around 4:00 PM. She stated she would update his care plan and would get the staff to assist him. As she was walking out of the resident's room, a staff member arrived to assist the resident.</p> <p>A review of the medical record revealed that Resident #63 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis, type 2 diabetes, Atrial fibrillation (AFIB) hypertension (HTN), and depression.</p> <p>A review of the Quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/20/25, revealed that the resident had a brief interview for mental status (BIMS) score of 10 out of 15 possible points, indicating moderate cognitive impairment. The assessment documented that the resident had upper extremity functional impairment on one side and was totally dependent on staff for bed mobility, toileting, dressing and transfers.</p> <p>2. An observation made on 4/21/25 at 12:15 PM, revealed that Resident #81's call light was on. The resident stated she needed her pain medication and her brief changed.</p> <p>On 4/21/25 at 12:30 PM, the MDS nurse answered the call light and notified the nurse. She stated she left the call light on per resident request.</p> <p>On 4/21/25 at 1:00 PM, Resident #81's call light was still on. A follow-up interview was conducted with Resident #81 at this time and she was asked if she had been assisted yet. She stated she received the pain medication but her brief had not been changed. She said, You see what I am talking about; my light has been on for an hour. She added that she had not seen her assigned CNA since this morning.</p> <p>On 4/21/25 at 1:45 PM, Resident #81 stated she had been changed because she refused to receive her lunch tray before being cleaned up.</p> <p>In an interview with CNA E on 4/23/25 at 11:37 AM, she stated the call light should be answered by all staff. If the resident's need is not met, the call light should be left on.</p> <p>A review of the facility's payroll based journal report for October 1 - December 31, 2024 revealed that the facility had excessively low weekend staffing and a one-star rating.</p> <p>During an interview with the Staffing Coordinator on 4/24/25 at 11:25 AM, she explained that the facility census determined the daily staffing needs. When asked how frequently the facility experienced staffing issues, she said approximately three days of every week (random days and shifts). She confirmed that the facility had staffing issues.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 4/24/25 at 1:51 PM, the Administrator stated no one should walk past a call light. She stated the best practice was to leave the call light on until the resident's needs had been met. If the call light was turned off and the need was not met, the person turning off the call light should notify the resident about the situation. She said, For example, of a resident requests medication, the person can turn off the light and notify the nurse, then go back to the resident and explain the expected timeframe to receive the medication (For example, the nurse was passing medication to another resident, and she/he would be with you shortly.) When asked how soon resident needs should be addressed, she said whenever practicable. She was then asked about the PBJ (Payroll Based Journal) reporting. She stated the facility had contracted with an outside agency that was completing the reporting. She provided the contact information for the agency.</p> <p>During a telephone interview on 4/24/25 at 3:01 PM with a representative of the PBJ reporting agency, he explained that the information for PBJ was obtained from the facility's payroll. He stated before the report was submitted, he verified the data to ensure accuracy. He confirmed that the facility triggered for low weekend staffing and the concerns were relayed to the [NAME] President of Operations (VPO).</p> <p>In an interview on 4/24/25 at 3:14 PM, the VPO stated she was not aware of the low weekend staffing. She acknowledged that the facility had staffing issues and mentioned that she would put in place a staffing initiative plan. She added that the facility had posted advertisements for positions and was in the process of hiring a weekend manager.</p> <p>A review of the facility's Assessment Tool (updated on 3/21/240, revealed that the facility was licensed for 120 residents and the daily average was 100 residents.</p> <p>On Page 2: Acuity: Indicated that the facility utilized the CMS 802 as a resource to determine acuity. The facility also utilized a patient-driven payment model (PDPM) distribution report from Team TSI. This report generated a non-therapy ancillary (NTA) score based on submitted MDSs to determine nursing acuity. For long-term care residents, the facility utilized the ADL (activities of daily living) score generated from the MDS to determine nursing acuity. The assessment indicated that the average number of residents with behavioral health needs was 60.</p> <p>On Page 7: Individual staff assignment was determined based off the acuity. If the clinical staff observes high acuity, then additional staff will be needed. (Copy obtained).</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45153</p> <p>Based on interviews, record review, and a review of facility policies and procedures, the facility failed to 1) Ensure that the consultant pharmacist's Medication Regimen Reviews/Recommendations were maintained/ followed to minimize or prevent adverse consequences to the extent possible for one resident (#30), and 2) Ensure that the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist for one resident (#23) of five residents reviewed for unnecessary medications, from a total survey sample of 38 residents.</p> <p>The findings include:</p> <p>1. A review of Resident #30's Consultant Pharmacist Medication Regimen Review for 3/31/25 revealed recommendations made and agreed upon by the physician to either discontinue Apixaban or reduce Eliquis to 2.5 milligrams by mouth two times per day for a history of Deep Vein Thrombosis (DVT) were not carried out by the facility.</p> <p>A review of Resident #30's medical record revealed an admitted [DATE]. His diagnoses included encephalopathy, bipolar disorder, major depressive disorder, long-term (current) use of anticoagulants, long-term (current) use of insulin, chronic pain, and heart failure.</p> <p>A review of Resident #30's active physician's orders included the following:</p> <ul style="list-style-type: none"> <li>- Depakote Oral Tablet Delayed Release, 250 milligrams (mg), give 1 tablet by mouth two times a day for bipolar disorder (4/17/2025-4/22/2025)</li> <li>- Depakote Oral Tablet Delayed Release, 250 mg, give 1 tablet by mouth two times a day for bipolar disorder (04/22/2025)</li> <li>- Depakote Oral Tablet Delayed Release, 500 mg, give 1 tablet by mouth two times a day for bipolar disorder (4/17/2025-4/22/2025)</li> <li>- Depakote Oral Tablet Delayed Release, 500 mg, give 1 tablet by mouth two times a day for bipolar disorder, (4/22/2025)</li> <li>- Eliquis Oral Tablet 5 mg, give 1 tablet by mouth every 12 hours for DVT (8/10/2024)</li> <li>- Gabapentin Oral Capsule 400 mg, give 1 capsule by mouth every 12 hours for neuropathy (08/10/2024)</li> <li>- Lantus SoloStar Subcutaneous Solution Pen-injector 100 units/milliliter (units per milliliter), inject 10 units subcutaneously two times a day for diabetes mellitus (2/19/2025)</li> <li>- Novolog FlexPen Subcutaneous Solution Pen-injector 100 units/milliliter, inject 8 units subcutaneously before meals and at bedtime for diabetes mellitus (2/19/2025)</li> </ul> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The electronic medical record (EMR) Miscellaneous Tab revealed a recommendation made by the consultant pharmacist on 3/31/2025; no response from the physician was noted.</p> <p>A review of the Quarterly Minimum Data Set (MDS) assessment, dated 02/12/25, revealed the resident had a Brief Interview for Mental status (BIMS) score of 11 out of 15 possible points, indicating moderate cognitive impairment. High-risk drug class medications documented included an anticoagulant. Other high-risk drug class medications included antipsychotic, antidepressant, hypoglycemic, and anticonvulsant medications. Antipsychotics were received on a routine basis only; a GDR (gradual dose reduction) was completed on 2/6/2025 and was noted not clinically contraindicated. A review of the April 2025 Medication Administration Record (MAR) revealed that medications were administered as ordered by the physician.</p> <p>On 4/24/25 at 2:02 PM, the Regional Nurse Consultant reported that per the pharmacy, no recommendations had been made for Resident #30 since 11/2024. A copy of the pharmacist's medication review was requested.</p> <p>On 4/24/25 at 4:17 PM, the completed pharmacist's medication review form, dated 3/31/2025, was received and identified that a recommendation was made but there was no physician's response. No other consultant pharmacist reviews were provided.</p> <p>On 4/24/25 at 8:09 PM, the Regional Nurse Consultant confirmed that all pharmacist medication reviews identified were reviewed and signed by the physician. The Regional Nurse Consultant reviewed the facility's pharmacist medication book and stated he would continue to search for signed copies that were not in the binder.</p> <p>On 4/24/25 at 8:20 PM, the Regional Nurse Consultant provided a pharmacist medication review dated 3/31/2025 that revealed the physician's response: Agree, please write order.</p> <p>48947</p> <p>2. A review of Resident #23's monthly Pharmacy Recommendations/Reviews from 8/2024 through 4/2025, revealed that the only recommendations/reviews available were for the months of 8/30/24, 9/30/24, and 1/2025. The facility was unable to provide evidence that the consultant pharmacist was completing monthly medication reviews for this resident.</p> <p>A review of Resident #23's medical record revealed an admitted [DATE] and diagnoses including atherosclerotic heart disease, other specified polyneuropathies, diabetes mellitus - type 2, low back pain, anxiety disorder, other chronic pain, insomnia, alcohol abuse, pin in left hip, pain in right leg, Peripheral Vascular Disease (PVD), polysubstance abuse, ADHD (attention deficit hyperactive disorder), and depression/mood disorder.</p> <p>A review of the annual MDS (minimum data set) assessment, dated 2/21/25, revealed the resident had a BIMS (brief interview for mental status) score of 13 out of 15 possible points, indicating intact cognition. He was documented with no behaviors; he required set-up or clean-up assistance with eating, and was independent with toileting, bed mobility and transfer tasks. The assessment also indicated pain that occasionally interfered with day-to-day activities, at a 7 on a numerical scale of 0-10 with 10 being the worst possible pain. During the assessment look-back period, the resident received antianxiety, antidepressant, diuretic, opioid, and anticonvulsant medications.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the resident's active Care Plan revealed the following focus areas:</p> <ul style="list-style-type: none"> <li>- Alteration in usual functional performance in self-care related to weakness, debility, neuropathy (created 2/24/25, revised 3/12/25)</li> <li>- I have an ADL (activities of daily living) self-care performance deficit related to unsteady gait, balance, neuropathic pain, chronic pain, (CAD) Coronary Artery Disease, muscle spasms. I will refuse showers/bathing (created 3/29/23, revised 3/13/25).</li> <li>- I am receiving an over-the-counter sleep aid related to Insomnia (created 3/29/23, revised 3/13/25).</li> <li>- I am receiving an antidepressant for a diagnosis of depression (created 3/29/23, revised 3/13/25).</li> <li>- I am receiving an antianxiety medication for a diagnosis of anxiety disorder (created 3/29/23, revised 3/13/25).</li> <li>- I am receiving diuretic therapy related to hypertension (created 2/24/25, revised 3/13/25).</li> <li>- I have acute, chronic pain related to a diagnosis of low back pain, chronic pain, muscle spasms, neuropathic pain, and degenerative joint disease (created 3/29/23, revised 3/13/25).</li> </ul> <p>A review of the active physician's orders revealed orders for the following:</p> <ul style="list-style-type: none"> <li>- Alprazolam 0.5 mg (milligrams) by mouth twice daily for anxiety (5/26/24)</li> <li>- Torsemide 20 mg by mouth daily for edema (6/28/24)</li> <li>- Methadone 10 mg, give 4 tablets by mouth daily (9/25/24)</li> <li>- Trazodone 100 mg by mouth at bedtime for major depressive disorder, insomnia (2/13/25)</li> <li>- Percocet 5-325 mg by mouth every 4 hours as needed for joint pain (3/14/25)</li> <li>- Non-pharmacological interventions use every shift (9/30/24)</li> <li>- Assess for pain every shift (5/26/24)</li> <li>- Behavior Monitoring every shift (5/26/24)</li> <li>- Side effects monitoring every shift (5/26/24)</li> </ul> <p>A review of the resident's psychiatric progress notes revealed that he was followed by psychiatric care and services monthly and as needed for depression, anxiety, insomnia and alcohol abuse.</p> <p>A review of the April 2025 Medication Administration Record (MAR) revealed that all medications were administered as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy titled Monthly Drug Regimen Review (N-866, effective: 04/21/2017, revised 3/28/2024), revealed:</p> <p>Procedure: To ensure the requirement is met for monthly drug regimen review, the ED/DON should implement the following process:</p> <p>Downloading of Pharmacist Consultant Report: Available from contracted pharmacy via secure email or database</p> <p>-Day 15-21 the DON/designee will contact the physicians with any outstanding recommendations, if no response from physician, the facility may notify the Medical Director for further assistance.</p> <p>Consultant Report-Continuous Print</p> <p>This report to be used by the DON/designee to record responses returned from the physician and for follow-up on any outstanding recommendations.</p> <p>If follow-up for consultant pharmacist recommendations are not completed within the specified time frame, this should be reported to the Medical Director for follow up with attending physician as indicated.</p>		