

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105611	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER Aviata at Greenacres		STREET ADDRESS, CITY, STATE, ZIP CODE 6414 13th Rd S Green Acres, FL 33415	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure appropriate care and services related to seizures for 1 of 3 sampled residents as evidenced by the failure to monitor for seizure activity, failure to implement seizure precautions, and failure to assess and implement interventions during a seizure for Resident #2. The findings included: Review of the record revealed Resident #2 was admitted to the facility on [DATE] with a diagnosis of convulsions. Review of the hospital record for the stay just prior to admission, revealed the resident had a new onset seizure while in the hospital. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented a diagnosis of seizure disorder. Review of the physician orders and Medication Administration Record (MAR) documented Resident #2 received Lacosamide (an anti-seizure medication) twice daily as of 04/27/26 and Keppra (an anti-seizure medication) as of 04/28/26. The record lacked any care plan related to care and services or interventions for seizures. Review of a physician progress note dated 05/23/26 with a date of service as 05/21/26 documented staff were to implement seizure precautions for Resident #2. This was documented again on 06/07/26 for the service date of 06/04/26. Review of a nurse practitioner progress note dated 05/15/26 documented nursing staff were instructed to continue monitoring for seizure activity. Additional progress notes dated 05/22/26, 05/25/26, 05/29/26, and 06/01/26 all documented to monitor for seizures. A nursing progress note dated 06/05/26 at 5:09 AM documented, Patient was sent to the hospital following a seizure episode around 0450 (4:50 AM). After several intervention we called 911. They take him to the hospital. A Change In Condition form dated 06/05/26 at 5:23 AM simply documented Resident #2 had a seizure with vitals that were obtained at 5:25 AM through 5:27 AM. The record lacked any evidence of either the implementation of any seizure precautions or seizure monitoring. The record also lacked any documentation as to the type of seizure or condition of the resident, the length of the seizure, and specifically what interventions were implemented. During an interview on 06/09/26 at 1:11 PM, when asked what seizure precautions were, Staff A, Registered Nurse (RN) stated having the bed in the lowest position, side rail pads, and possibly floor mats. When asked what should be done if a resident was having an active seizure, the RN stated she would put the resident on their side, complete an assessment with vitals, and if the resident became unresponsive, she would send them out to the hospital. The RN stated if the resident was on precautions she would have to monitor the resident. When asked how that would be documented, the RN stated it would be an order and she would document in the MAR. During an interview on 06/09/26 at 1:43 PM, when asked what seizure precautions were, the Assistant Director of Nursing (ADON) stated they would include having the bed in the low position and side rail pads if the side rails were being utilized. When asked what should be done if a resident was having a seizure, the ADON stated they should ensure the residents safety and a clear environment and ensure airway clearance after the seizure. When asked what the nursing staff should document after a resident had a seizure, the ADON stated she would expect to see a description of what happened, to include describing the seizure, and what the staff did for the resident. Staff nurses should also notify the physician and family, as appropriate. When asked if she was aware of the recent seizure activity for Resident #2, the ADON stated she was not. When shown (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the documentation by Staff A, RN, the ADON agreed it was not complete. During an interview on 06/09/26 at 2:10 PM, when asked what she expects her staff to do if a resident was having a seizure, the Director of Nursing (DON) stated she would expect the resident to be in a low bed, turn them to their side, ensure their safety, and time the seizure. The DON stated If the resident had any as needed medication for active seizures, she would expect staff to provide those meds. If the resident continued to seize, she would expect her staff to send the resident out via 911 services. When asked if she was aware of the recent seizure for Resident #2, the DON stated she was as she received a phone call from the night nurse about 5:30 AM, she believed. The DON volunteered she instructed the nurse to time the seizure and to document her observations. When asked about seizure precautions, the DON stated they don't do the padded side rail intervention and was unsure why. The DON also stated there should be an order to observe and monitor for seizures.		