

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

Printed: 10/09/2026
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 07/23/2026
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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to provide copies of an itemized bill as requested for 1 of 3 sampled residents (Resident #4). The findings included: During a phone interview on 07/22/26 at 9:04 AM, Resident #4 explained after her discharge from the facility, and upon receiving statements from her insurance company, she had phoned the facility on four different occasions requesting an itemized bill of services. Resident #4 explained she had spoken to the receptionist on two occasions, and was transferred to the billing person once, who told her it would be available the next day. Resident #4 stated she phoned the next day and was told it wasn't ready but that a message would be given to the billing person. Resident #4 stated she never got the requested itemized bill from the facility. Review of the record revealed Resident #4 was admitted to the facility on [DATE] and was discharged on 02/06/26. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. During an interview on 07/23/26 at 11:50 AM, when asked the process to provide a requested itemized bill, the Business Office Manager (BOM) stated she would just print it out and provide it to the resident. The BOM then clarified they do have a third-party billing system so she would request the itemized bill, would usually get it within a day or so, and would then print it out for the resident. When asked what she would do if a discharged resident called and requested an itemized bill, the BOM stated she would get the resident's email address and send it that way, or send it via mail. When asked if she kept any log or any documentation of requested items, the BOM stated she did not. During the continued interview, when asked if she provided an itemized bill to Resident #4, the BOM stated she recalled the resident requesting it and looked through her emails. The BOM located emails on her phone and stated the resident called on 05/04/26 and requested the itemized bill to discuss with her insurance company, and she in turn requested it from their third-party billing company that same day. The BOM stated she did not receive it so sent a follow-up request on 05/13/26 and received it on 06/08/26. The BOM looked through her emails and stated she had sent it directly to the resident's insurance company and further stated, Oh . that's on me. I never sent it to her (Resident #4). When asked if there was any reason she did not send it to Resident #4, the BOM stated, No. When asked if there was any written process or policy related to provision of requested item from the business office, the BOM stated she did not think so.		

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: 105611	Facility ID: 105611
		If continuation sheet Page 1 of 3

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a proper and timely discharge process for 2 of 3 sampled residents as evidenced by the failure to complete the Discharge Plan and Instructions for Residents #4 and #5, failure to ensure timely set-up and provision of Home Health Agency (HHA) services and Durable Medical Equipment (DME) for Resident #4, and failure to ensure a timely transfer or attempt to transfer Resident #5 as per family request. The findings included: Review of the policy Discharge of Resident to Home or Other Center, revised 03/24/25, documented in part, Procedure: 1. Upon determination by the interdisciplinary team that resident is appropriate for discharge, the Nurse will obtain a physician's order for discharge to include: a) Place of discharge, b) Community resources or referrals required, c) Status of medications on discharge (i.e. May discharge home with med). 2. Complete the Discharge Plan and Instructions. 5. Provide resident/resident representative a copy of the Discharge Plan and the pharmacy medication list. 6. Document final disposition in the resident's clinical record. Review of the policy Interdisciplinary Discharge Planning, revised 04/28/25, documented in part, Procedure: . 2. a. Social Services/designee is responsible for identifying and coordinating necessary outside services and document in the medical record. 3. Prior to discharge, the discharge plan including the proposed discharge date will be reviewed with the resident/resident representative. 1) Review of the record revealed Resident #4 was admitted to the facility on [DATE] and was discharged on 02/06/26. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. Resident #4 had been admitted to the facility after a car accident in which she sustained a broken right leg, broken left foot, broken left arm and hand, and neck strain. During a phone interview on 07/22/26 at 9:04 AM Resident #4 confirmed the above fractures and stated she was non-weight bearing throughout her stay at the facility and for a total of three months afterward, thus was essentially bed and wheelchair bound. The resident also explained during her stay at the facility she had out-patient surgery on her left wrist. When asked about the discharge process, the resident explained the social worker had told her they would set up home health services and equipment. On the day of her discharge someone informed her they were working on the discharge. The resident explained that she lived alone but found family that would take her into their home. Resident #4 stated she called the equipment company because her family member was going to pick up the wheelchair, but the equipment company did not have the orders so wouldn't have the wheelchair for her. The resident explained that someone finally got ahold of the social worker via phone, as she had gone home for the day, and the social worker allowed her to borrow the facility wheelchair. Resident #4 stated at about 5:30 PM a nurse said goodbye and left, without going over any discharge papers. The resident explained the next day she looked at the papers that were essentially blank and had to call her managed care company to find out what home health agency to use. The resident stated she did not get home health services for several days. Review of the progress notes lacked any documentation related to the discharge of Resident #4. A physician progress note dated 02/06/26, the day of her discharge, documented, Disposition: Continue skilled nursing care with multidisciplinary support. Further review of the record revealed the Discharge Plan and Instructions that had only seven of the eleven sections completed. This form completed by the Social Services Director (SSD) on 02/06/26 documented that Resident #4 was returning home with her spouse or family and that she would have home health services, with a (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	referral made to the resident's managed care provider, and DME to include a 3 in 1 drop arm commode. A document titled Response to Fax Request from the resident's managed care provider, time-stamped 02/09/26 at 10:40 AM, three days after discharge, documented the resident would start home health services on 02/11/26, five days after discharge from the skilled nursing facility. During an interview on 07/23/26 at 12:02 PM when asked about the discharge process related to home health services and DME, the Social Services Director (SSD) explained the process depends upon the insurance company involved, but generally the day before discharge she will make the necessary arrangements for the resident. When asked specifically about Resident #4's discharge, the SSD stated she wasn't sure but would have sent out the referral to the management care provider and DME the day prior to her discharge. The SSD volunteered that she recalled the DME couldn't provide the wheelchair on the day of discharge, so she allowed the resident to borrow one from the facility. The SSD provided a text message that documented the initiation of DME on 02/06/26, the day of discharge. When shown the managed care provider faxed response indicating the home health services would not start until 02/11/26, five days after discharge from the facility, the SSD agreed with the findings and stated she would look for the faxed referral information. During a subsequent interview on 07/23/26 at 1:05 PM, the SSD provided the faxed referral packet with a handwritten date of 02/06/26 on the fax cover sheet. Further review of the packet revealed the Order Summary Report that included the medications was time-stamped 02/09/26, three days after discharge. When asked about the discrepancy the SSD had no explanation. 2) Review of the record revealed Resident #5 was admitted to the facility on [DATE] and discharged on 06/01/26. The resident had suffered a traumatic brain injury after a car accident. Progress notes revealed the following: a) A progress note dated 07/30/25 documented a referral was sent to another nursing facility on 07/18/25 and the resident was denied admission. b) On 05/15/26 a referral was sent to another nursing facility and they were waiting approval. c) On 05/29/26 a referral was sent to a sister facility per family request to be closer to [NAME] County. The referral was accepted and the transfer date was set for 06/01/26. d) On 06/01/26 Resident #5 was transferred to their sister facility in [NAME] County. Review of the Discharge Plan and Instructions dated 06/01/26 revealed the document was not completed. During an interview on 07/23/26 at 12:15 PM, when asked about the transfer request by the family and transfer process for Resident #5, the SSD explained that at first her mother wanted her to live at home, but she lived in a two-story townhome that would not work for them. Then the family stated they wanted the resident to be closer to home so they could be more involved in her care. The SSD stated she told the mother it would not be easy to find a place due to her very young age and level of care and insurance. When shown the progress notes documenting the transfer process started the previous year on 07/18/25 with no follow-up until 05/15/26, the SSD agreed, again stating it was difficult to find a facility that would accept the resident, but had no evidence of any other attempts. When shown the Discharge Plan and Instructions document, the SSD agreed it had not been completed.		