STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105632	A. Building B. Wing	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Harts Harbor	11565 Harts Rd Jacksonville, FL 32218

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, interviews, and facility policy and procedure review, the facility failed to provide adequate supervision to prevent the elopement for one (Resident #1) of 12 residents identified as at risk for elopement and failed to provide staff training on the facility's Leave of Absences (LOA) process. Resident #1 was allowed to sign himself out of the facility despite being evaluated as an elopement risk. Review of the medical record for Resident #1 revealed an admission date of 3/17/23 and re- entry on 7/7/24. His diagnoses included metabolic encephalopathy, obesity, major depressive disorder, alcohol abuse, insomnia, tobacco use and anxiety disorder.Review of Resident #1's Care plan initiated on 11/15/23 indicated he may go out on LOA with meds and escort. Resident/family members must sign out every LOA. Resident was care planned as an elopement risk/wanderer related dementia and impaired safety awareness. The resident will not leave facility unattended. Interventions included to assess for elopement risk, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Resident prefers electronic monitoring device: a wander guard on right wrist needs to be changed 7/20/26.Further record review revealed that on 8/23/25, Resident #1, went to the receptionist and requested to sign out of the facility. The receptionist provided the resident the sign out book, which he signed and exited the facility through the main entrance.Review of Resident #1 current physician orders revealed the following:-Wander guard - Expiration Date 7/26.-Wander guard - Check for placement on Right wrist every shift for monitoring 5/30/24.- Wander guard - Check for function each day- every night shift for monitoring 7/20/23.- May go out with responsible party 3/18/23.- Document Resident behaviors every shift r/t exit seeking- every shift for patient safety - 8/24/25.Review of Behavior note dated 8/23/25 for Resident #1 revealed the on-call Team Health was notified regarding elopement.Review of Behavior note dated 8/24/25 for Resident #1 indicated that the resident continued to be 1:1 supervision, no changes noted at this time in the client or client condition, staff will continue to monitor the client.Review of Social Services note dated 8/25/25, revealed the Director of Social Services discussed the elopement that occurred with resident. Resident reported he does not remember signing himself out or trying to cross the street. Resident reported he is not trying to leave the facility and feels safe.During an interview with Employee A, Human Resource Coordinator (HRC) on 10/22/25 at 1:22 pm, she stated that on 8/23/25, she was the manager on duty. She explained that she was at the front desk when Resident #1 asked to sit on the porch. The receptionist asked if he could go out, and I told him he had to sign out. The HRC came back to the front and looked outside. She saw what appeared to be a man standing on the facility's lawn. She asked the receptionist if that was the resident who asked to go outside. She noticed his wheelchair was still in the facility. Resident #1 had walked to the neighbor across the street to ask for a ride to the store. The HRC then went outside and helped the resident back to the facility with the assistance of the neighbor across the street. When asked if the resident was wearing a wander guard, she stated she did not recall him having a wander guard on. When asked about the LOA process, she stated that she was not aware of the process and assumed the receptionist knew the process. During a phone interview on 10/22/25 at 1:45 pm, with Employee B, Receptionist, she stated that she has been working at the facility for almost a year. She stated that prior to the incident she had not participated in any type of drill. She explained that when a resident wants to go out, she checks to see if the resident is permitted to leave the facility with or without someone with them. When asked about Resident #1, she explained that she was not aware of the caution elopement book and had not been informed of it. She thought that if residents had a sheet on their sign out book they could go outside. She explained that the HRC asked her to sign the resident out. The resident had a wheelchair but got up and walked out of the facility and did not say where he was going. She confirmed that she had not received any training on LOA. On 10/22/25 at 2:09 PM, an interview was conducted with the Director of Nursing (DON). He explained that the facility conducted elopement assessment upon admission, quarterly, on change on condition and any elopement incident. He mentioned elopement drills are conducted at least monthly and can be conducted more frequently. Drills are conducted by the maintenance department. However, when there is an incident all the department heads can assist. When asked about the LOA process, he explained that the resident must sign out with the nurse then the receptionist at the front. The receptionist verifies with the nurse that the resident has signed out at the nurse's station. If they are going out for an extended time the nurses coordinate with the pharmacy and physicians to make sure all the patient's orders are in place. When asked about the incident with Resident #1, he explained that on 8/23/25 the weekend supervisor informed him that

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy and procedure review, the facility failed to implement appropriate plans of action to correct identified quality deficiencies related to elopement. Facility staff permitted Resident #1 who was an elopement risk to sign out of the facility without an escort. The facility did not implement the corrective action noted in their Performance Improvement Plan (PIP). There was a total of 12 residents at risk for elopement. Review of the medical record for Resident #1 revealed an admission date of 3/17/23 and re- entry on 7/7/24. His diagnoses included metabolic encephalopathy, obesity, major depressive disorder, alcohol abuse, insomnia, tobacco use and anxiety disorder.Review of Resident #1's Care plan initiated on 11/15/23 indicated he may go out on LOA with meds and escort. Resident/family members must sign out every LOA. Resident was care planned as an elopement risk/wanderer related dementia and impaired safety awareness. The resident will not leave facility unattended. Interventions included to assess for elopement risk, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Resident prefers electronic monitoring device: a wander guard on right wrist needs to be changed 7/20/26.Further record review revealed that on 8/23/25, Resident #1, went to the receptionist and requested to sign out of the facility. 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Resident reported he does not remember signing himself out or trying to cross the street. Resident reported he is not trying to leave the facility and feels safe.Resident #1 had only two Elopement assessment dated [DATE], 7/21/24 which indicated that the resident was at risk of elopement.During an interview with Employee A, Human Resource Coordinator (HRC) on 10/22/25 at 1:22 pm, she stated that on 8/23/25, she was the manager on duty. She explained that she was at the front desk when Resident #1 asked to sit on the porch. The receptionist asked if he could go out, and I told him he had to sign out. The HRC came back to the front and looked outside. She saw what appeared to be a man standing on the facility's lawn. She asked the receptionist if that was the resident who asked to go outside. She noticed his wheelchair was still in the facility. Resident #1 had walked to the neighbor across the street to ask for a ride to the store. The HRC then went outside and helped the resident back to the facility with the assistance of the neighbor across the street. When asked if the resident was wearing a wander guard, she stated she did not recall him having a wander guard on. When asked about the LOA process, she stated that she was not aware of the process and assumed the receptionist knew the process.During a phone interview on 10/22/25 at 1:45 pm, with Employee B, Receptionist, she stated that she has been working at the facility for almost a year. She stated that prior to the incident she had not participated in any type of drill. She explained that when a resident wants to go out, she checks to see if the resident is permitted to leave the facility with or without someone with them. When asked about Resident #1, she explained that she was not aware of the caution elopement book and had not been informed of it. She thought that if residents had a sheet on their sign out book they could go outside. 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