| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105644 | A. Building<br>B. Wing | 09/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aviata at Fletcher | 518 W Fletcher Ave<br>Tampa, FL 33612 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>(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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105644 | A. Building<br>B. Wing | 09/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aviata at Fletcher | 518 W Fletcher Ave<br>Tampa, FL 33612 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to notify the physician a medication error had occurred for one resident (#5) out of four residents sampled.Findings included: On 09/30/2025 at 1:00 p.m , Resident #5 was observed lying down in bed with her call light within reach. She was observed with no signs of distress. She said approximately 2 weeks ago the nurse assigned to their room gave her, her roommate's medication and gave her roommate her medication. She said she did not have any negative effects, but she thought it was strange it happened. Resident #5 said she was not able to remember what medication was given to her, but she thinks she received 3 Tylenol tablets and 1 Gabapentin tablet. Review of an admission Record dated 09/30/2025 revealed Resident #5 originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include but not limited to unspecified open wound of abdominal wall, unspecified quadrant without penetration into peritoneal cavity, subsequent encounter, pressure ulcer of other site stage 3, nonrheumatic tricuspid (valve) insufficiency, nonrheumatic mitral (valve) insufficiency, cardiomyopathy, unspecified. Review of a Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) summary score of 15 which indicated intact cognitive abilities Review of physician order showed:Acetaminophen tablet 325 milligram (MG), give 2 tablets by mouth every 6 hours as needed for pain, fever, order date 07/12/2025 Gabapentin Oral capsule 30 milligram (MG) (Gabapentin) give 1 capsule by mouth three times a day for Nerve pain, order date 05/03/2025On 09/30/2025 at 12:45 p.m., an interview was conducted with the Director of Nurses (DON). She said Resident #5 was given her medication out of order during med pass. The DON said on 09/02/2025 she received a phone call informing her that the nurse gave Resident #5 her roommate's medication. She said it was not clear on the incident report what medications were given to each resident, but she was made aware that it was during the 5 p.m. medication pass. The DON stated, I don't see any documentation showing Resident #5 provider was notified regarding the incident. The DON said as she reviewed the chart, Resident #5 received her roommates Tylenol. She stated, Resident #5 has a PRN order for Tylenol, but she received the medication without requesting it. The DON said her expectations were if there is a medication error, the nurse should document the medication that was given to the resident, notify the MD, and the family and follow any recommendation the physician may have. On 09/03/2025 at 1:00 p.m. an interview was conducted with Staff A, Registered Nurse, RN. Staff A said she was in the middle of medication pass when someone approached her, and she got distracted. She said she made a mistake and gave Resident #5 her roommate's Tylenol. Staff A said she did not notify Resident #5's provider about the incident because the resident already had a PRN order for Tylenol, she just received it without her request. On 09/30/2025 at 2:30 p.m., an interview was conducted with Resident #5' provider. The provider said she was not notified about the medication error regarding Resident #5 receiving her roommate's medication. The provider said her expectation was that she should be notified about everything that goes on with her patients. She said she is at the facility at least twice a week, and no one had informed her about the medication incident. On 09/30/2025 at 4:20 p.m., an interview was conducted with The Nursing Home Administrator (NHA) and the Regional Nurse Consultant (RNC). The RNC said they don't have a policy specific to medication errors and notification to the provider. She said notifications for medication errors are considered a change in condition and should fall under those guidelines. Review of the facility policy titled, Notification of Change in Condition, Revision Date 12/16/2020 revealed, Policy: The Center to promptly notify the patient/ resident, the attending physician, and the resident representative when there is a change in the status or condition. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105644 | A. Building<br>B. Wing | 09/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aviata at Fletcher | 518 W Fletcher Ave<br>Tampa, FL 33612 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105644 | A. Building<br>B. Wing | 09/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aviata at Fletcher | 518 W Fletcher Ave<br>Tampa, FL 33612 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice related to the administration of Vancomycin. The facility failed to obtain and follow physician orders for Vancomycin laboratory services, and failed to report laboratory results to the physician and pharmacy for one resident (#2) of two residents sampled.Findings included: Resident #2 was admitted to the facility on [DATE] and discharged on 07/25/2025. Review of the admission Record showed diagnoses included but not limited to cellulitis of right lower limb and left lower limb, non-pressure chronic ulcer of left calf with fat layer exposed, non-pressure chronic ulcer right calf, diabetes, polyneuropathy, Chronic Obstructive Pulmonary Disease (COPD), muscle weakness, hypertension, encounter for therapeutic drug level monitoring, end stage renal disease (ESRD), anemia, edema, peripheral vascular disease (PVD), gastrostomy, myocardial infarction, and Methicillin-resistant Staphylococcus aureus (MRSA). Review of the admission Minimum Data Set (MDS) dated [DATE] showed in Section C, Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 15, meaning cognitively intact. Section GG, Functional Abilities showed the resident required substantial/ maximal assistance for toileting and shower and bathing. Review of the physician orders showed the following orders:Vancomycin HCl in Normal Saline (NaCl) Intravenous Solution 1.25-0.9 GM (gram)/250ML (milliliter)-% every 18 hours for bilateral lower extremities (BLE) infected wound for 14 days as of 6/17/25 to 07/01/25Vancomycin HCl in NaCl Intravenous Solution 1.25-0.9 GM/250ML-% in the morning for BLE (bilateral lower extremity) Infected wound from 07/08/2025 starting 07/09/25Pharmacy to dose Vanco as of 06/18/25Pharmacy to dose Vanco as of 07/21/25Pharmacy to dose Vanco as of 07/09/25Complete Blood Count (CBC) with differential (diff), Comprehensive Panel (CMP) ordered on 06/18/25 for 06/18/25Basic Metabolic Panel (BMP), Vancomycin Pre-dose (trough), sed rate (Erythrocyte sedimentation rate which monitors inflammation and infection) for 06/18/25Vancomycin pre-dose (trough), BMP ordered 06/19/25 for 06/23/25Vancomycin pre-dose (trough), sed rate, CMP, CBC with diff, hemoglobin A1C ordered 06/18/25 for 06/26/25Vancomycin pre-dose (trough), sed rate, CMP, CBC with diff, A1C ordered 06/18/25 for 06/27/25Vancomycin pre-dose (trough), sed rate, CMP ordered on 06/18/25 for 07/03/25Vancomycin Random ordered 07/14/25 for 07/14/25CBC with diff, CMP, sed rate, CRP Quantitative, Vancomycin random ordered on 07/14/25CBC with diff, CMP, sed rate, CRP (C-reactive protein) Quantitative, Vancomycin random as of 07/21/25Vancomycin pre-dose (trough) ordered on 07/23/25 for 07/24/25Vancomycin Random ordered 07/24/25 for 07/25/25BMP for 07/24/25Ok to transfer to ER (emergency room) per Infectious Disease (ID) Medical Doctor (MD) on 07/25/25 Review of Inpatient consult to Care Management dated 06/10/25 showed to perform CBC, BMP every Monday and Thursday. Vancomycin trough every Monday. Review of a handwritten script from the ID physician dated 07/07/25 showed CBC, CMP, UT or VT, ESR, CRP on Mondays and CBC, BMP on Thursdays and fax results to ID physician. Review of the Medication Administration Record (MAR) for June 2025 showed:Vancomycin HCL in NaCL Intravenous Solution 1.25-0.9 gm/250 ml every 18 hours for LLE (left lower extremity) infected wound for 14 days as of 06/17/25 discontinued on 06/19/25 administered on 06/17/25 to 06/19/25.Vancomycin HCL in NaCL Intravenous Solution 1.25-0.9 gm/250 ml in the morning for BLE infected wound as of 06/20/25 until 07/01/25 administered 06/20/25 to 06/27/25; on hold for 06/28/25 and 06/29/25; administered on 06/30/25. Review of the Medication Administration Record (MAR) for July 2025 showed:Vancomycin HCL in NaCL Intravenous Solution 1.25-0.9 gm/250 ml in the morning for BLE infected wound as of 07/09/25 until 07/24/25 administered 07/09/25 through 07/16/25; 07/17/25 dose was not administered; administered 07/18/25 to 07/21/25; 07/22/25 dose was not administered and the 07/23/25 was administered. Review of Lab results showed06/18/25 showed Vancomycin random was 14.7 (trough 10-20 ug/ml); (peak 18-40 ug/ml)06/19/25 showed Vancomycin trough was 27.8; sed rate of 82 (0-20)06/23/25 showed unable to obtain06/26/25 showed unable to obtain06/27/25 showed unable to obtain06/30/25 showed Vancomycin trough was 27.6; sed rate of 4607/03/25 showed vancomycin trough of 14.5; no sed rate; (after medications were stopped on 07/01/25)07/14/25 showed sed rate of 102 (Vanco trough not performed)07/21/25 showed sed rate of 121 (Vanco trough not performed)07/24/25 showed Vancomycin trough 33.907/25/25 showed Vancomycin random 32.6 Review of the physician and nursing progress notes showed:On 06/18/25, Resident new admit to facility, resident admitted on IV antibiotics Cefepime and Vancomycin until 07/01/25 for wound infection. Resident has history of ESBL (Extended - |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105644 | A. Building<br>B. Wing | 09/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aviata at Fletcher | 518 W Fletcher Ave<br>Tampa, FL 33612 |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews the facility failed to ensure residents were free from significant medication errors for three residents (#4, #5 and #6) of three sampled residents.Findings included:<br><br>1. Resident #4 was admitted on [DATE], readmitted on [DATE] and discharged on [DATE]. Review of the admission Record showed diagnoses included but were not limited to cerebrovascular disease, atrial fibrillation, diabetes, anemia in chronic kidney disease, neuromuscular dysfunction of bladder, stage IV chronic kidney disease, hypertension, stage III sacral pressure ulcer, stage III left heel pressure ulcer, and urine retention. Review of the quarterly, Minimum Data Set (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) of 14 or cognitively intact. Review of the Section GG, Functional Abilities showed the resident was dependent for toileting, showering and bathing. Section J showed he had no pain for last 5 days.<br><br>Review of the physician orders showed:<br><br>Morphine Sulfate concentrate oral solution 20 mg (milligram) / ml (milliliter) give 0.25 ml by mouth every 3 hours as needed for pain as of [DATE]<br><br>Do not resuscitate (DNR)<br><br>Assess resident every shift for pain<br><br>Terminal Diagnosis: the resident is diagnosed with a terminal condition and is at risk for loss of dignity during dying process related to the terminal diagnosis of Sequelae of Cerebrovascular Disease. Hospice services provided<br><br>Review of the [DATE] Medication Administration Record (MAR) showed<br><br>Assess resident for pain every shift.<br><br>[DATE], Pain assessed on days at a level of 0<br><br>[DATE], Pain assessed on evenings at a level of 0<br><br>Review of [DATE] MAR showed<br><br>Morphine Sulfate concentrate oral solution 20 mg (milligram) / ml (milliliter) give 0.25 ml by mouth every 3 hours as needed for pain as of [DATE]<br><br>[DATE] at 09:19 a.m. pain level of 7; given and effective; given by Staff G, Registered Nurse (RN)<br><br>[DATE] at 1629 or 4:29 p.m. level of 8 given and effective; given by Staff G, RN<br><br>[DATE] at 08:16 a.m. level of 7 given; given by Staff G, RN<br><br>Review of Medical Provider and nursing progress notes revealed the following:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105644 | A. Building<br>B. Wing | 09/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aviata at Fletcher | 518 W Fletcher Ave<br>Tampa, FL 33612 |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On [DATE] at 10:44 a.m. resident in hospice care. Resident noted with low blood pressure, 100/30, heart rate of 94, O2 (oxygen) saturation level was 80% with Oxygen at 2 Liters, respirations were 20. Resident appears weak and lethargic. Comfort measures provided by hospice protocol. Hospice nurse called. Staff H, Nurse Practitioner (NP) from insurance company was in facility. Primary Physician MD was aware and advised writer to stop regular medications on [DATE].<br><br>On [DATE], Staff H, Nurse Practitioner (NP) from insurance company wrote resident was being seen visit to follow-up on chronic conditions. (Resident) Was seen lying in bed, chronically ill appearing, eyes closed, sleep, appears weak/fatigued. Minimal conversation. Drifts back to sleep. Denies chest pain, shortness of breath, fever, chills, cough/congestion. Per nursing this a.m., the blood pressure was 100/32, with oxygen saturation at 80% at 2 liters per minute. Rechecked by NP, blood pressure was 100/60, heart rate 51, respirations 20, oxygen saturation at 94% with 4 liters of oxygen via nasal cannula. Call placed to Hospice services, waiting on return call from Hospice MD to discuss. Discussed with Primary Provider MD in agreement to discontinue Atorvastatin, iron, GDR of Desvenlafaxine, defer work up of leukocytosis, presumptive UTI (Urinary Tract Infection) with chronic indwelling Foley/recurrent UTIs, Hospice status. Discussed Plan of Care with nursing requested nursing notify provider for any changes in status.<br><br>On [DATE] at 8:00 a.m. Staff F, LPN (Licensed Practical Nurse) weekend supervisor wrote upon assessment this writer observed resident exhibiting signs of labored breathing, audible moaning, and involuntary twitching. Hospice was informed of change in condition. Awaiting call back from Hospice Nurse for estimated time of arrival.<br><br>On [DATE] at 8:38 a.m. Staff F, LPN, weekend supervisor entered the resident's room, upon assessment the resident was noted with no pulse or respirations. His code status was verified with two nurses. The resident's code status was verified as Do Not Resuscitate. The DON (Director of Nursing) was notified.<br><br>On [DATE] at 8:55 a.m. showed at 8:39 a.m., call received from Hospice Nurse, indicating an estimated time of arrival of 15 minutes. The resident expired at 8:42 a.m., and the Hospice Nurse arrived at 8:50 a.m., pronouncing the resident's death at 8:58 a.m. The family was notified at 9:00 a.m.: however, there was no answer, and a message was left. Resident's insurance company was notified at 9:02 a.m., and communication occurred with their staff. Staff H, Nurse Practitioner (NP) with insurance company was notified at 9:28 a.m.<br><br>On [DATE] at 1:06 p.m., a Change in Condition (CIC) showed resident had expired. Resident pronounced dead by hospice nurse. Family and MD notified.<br><br>Review of the care plans showed:<br><br>Resident had a terminal prognosis related to Cerebrovascular disease and was receiving hospice services. Interventions included but not limited to observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain. Date Initiated: [DATE]<br><br>Review of the Weights and Vitals Summary showed<br><br>[DATE] at 12:35 a.m. blood pressure: 102/70<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105644 | A. Building<br>B. Wing | 09/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aviata at Fletcher | 518 W Fletcher Ave<br>Tampa, FL 33612 |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | [DATE] at 4:26 p.m. blood pressure: 112/52<br><br>[DATE] at 1:34 a.m. blood pressure: 123/55<br><br>During an interview on [DATE] at 10:12 a.m. with the Nursing Home Administrator (NHA), Regional Registered Nurse (RN) and Director of Nursing (DON). The DON stated she was called in on [DATE] for what they identified as a discrepancy of the narcotic count. She stated she came in and reconciled all the medication carts with all the nurses at 7 p.m. At that time, she verified there was a discrepancy with Resident #4's liquid Morphine. Staff I, RN was working the day shift and was doing the medication pass from 7 a.m. to 7 p.m. Staff J LPN was coming on at 7 p.m. and found the discrepancy during narcotic reconciliation. Staff I, RN, was suspended due to possible drug diversion. The DON stated on [DATE] she came in and questioned Staff G, RN after looking at the inventory form and discovering she was the last person to administer the Morphine to Resident #4. The DON asked Staff G, RN how she administered the Morphine. Staff G picked up a medication cup and stated she administered it using the cup. Staff G was then pulled into office for a more in-depth interview. Staff G admitted to using the medication cup for measuring the morphine instead of a syringe. Staff G was asked to review the dosage she poured up of 2.5 ml to the actual order of 0.25 ml. Staff G, RN, was taken off the medication cart. The DON stated during the interview with Staff G, she disclosed she administered 2.5 ml of morphine for the three doses. The DON stated, once we calculated the 2.5 ml for three doses, that was what was removed or missing that we originally thought was a drug diversion. Staff G RN did a return demonstration of what she delivered. The DON asked Staff G why she gave the pain meds, and she stated that she guessed the pain level. The DON asked Staff G what the appropriate way would be to assess the pain level. Staff G stated using the PAINAD (Pain Assessment in Advance Dementia) scale. The DON stated Staff G was suspended at that time pending an investigation. On [DATE], Resident #4 received 2 doses and 1 dose on [DATE]. The NHA stated Staff G realized she made a medication error during her demonstration. The NHA stated it was documented on the Hospice note that the resident had a slow decline on the visit note of [DATE]. The NHA stated on [DATE] a note from Staff I, RN showed the resident was a hospice resident and was weak and lethargic, blood pressure of 100/30 (documented in a progress note). The NHA stated the progress note from Staff H, NP showed he was chronically ill, eyes closed, appears weak and fatigue, minimal conversation, back to sleep, blood pressure 100/32, oxygen saturation at 80% on 2 liters of oxygen. The NHA stated Staff H, NP documented she rechecked the blood pressure and it was 100/60, Oxygen saturation to 94% on 4 liters of oxygen. The note showed Staff H contacted hospice and was awaiting on return call. Staff H discussed the resident with his Primary Provider MD to discontinue medications and discounted plan of care with nurse. The NHA stated the Medical Director, and his Primary Provider could not say whether the added medication added to his (Resident #4's) decline or not. The NHA stated she interviewed Staff H, NP and she could not say whether the dosage caused anything or not.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105644 | A. Building<br>B. Wing | 09/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aviata at Fletcher | 518 W Fletcher Ave<br>Tampa, FL 33612 |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on [DATE] at 11:21 a.m. Staff H, NP with insurance company stated they specialize in long term care, and they work in conjunction with the Primary Provider MD. She stated they are another set of eyes and ears. She stated she was at the facility a couple days a week. She stated when she saw the resident she saw he was declining. Staff H stated she was not surprised that he had passed over the weekend. He had stage 4 chronic kidney disease. He had more than 9 lives due to kidneys and co-morbidities. She stated he was normally alert and awake, and he was not doing that on her last visit. He was in hospice. They were starting to cut medications. She stated she made numerous calls to the family trying to let them know he was declining. She confirmed with the nurse on [DATE] that he was on morphine and it had already been ordered. She stated he did not appear to be in any pain on [DATE] but she wanted it to be available to him. Staff H, NP stated she found out about the med error the following week. She stated they called her to let her know he had passed. She stated later that week, she found out about the discrepancy in meds and a med error had been made. She stated she thinks death was imminent. She stated the pain medication helped with the comfort. She stated on [DATE] he looked like a limp rag. His vitals were abnormal. She stated she called the family and Hospice that he was rapidly declining. She stated she spoke with the Primary Provider MD about an antibiotic for possible UTI. He was on medication for anemia, but it was not helping.<br><br>During an interview on [DATE] at 1:02 p.m. the pharmacy consultant stated he has a form he uses to audit narcotic counts and provide education. The nursing staff are to identify the resident, look for the medication in the narcotic logbook, use the MAR in the PCC, check to see if medication was scheduled or PRN (as needed), assess the pain level. The staff is supposed to use a medication cup on the cart, stable surface, eye level for pouring into. If using small doses should use a syringe to draw up. He stated to make sure the resident was sitting up and swallowed the medication completely. Ensure both logbook and the electronic chart or MAR are documented / signed. If order was less than 2- or 3-ml dosage, use a syringe to draw the medication up. He stated that reconciliation of medications should come after change of shift at a minimum.<br><br>On 9/30 at 12:58 p.m. a telephone call was made to Staff G, RN. Staff G would not speak with this surveyor.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105644 | A. Building<br>B. Wing | 09/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aviata at Fletcher | 518 W Fletcher Ave<br>Tampa, FL 33612 |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on [DATE] at 1:51 p.m. Staff F, LPN, weekend supervisor stated she had just come on shift on a Saturday. She stated she overheard the night nurse give a report to the oncoming day nurse. The night nurse said Resident #4 had been actively dying. He was only opening his eyes. Staff F stated she went in and checked on him, he did not act like he normally does. She checked on him through the shift. She stated staff H, NP had followed up with hospice already. Staff F stated he was fine on Saturday, comfortable. Staff F stated we left Saturday night ([DATE]) and he was comfortable. She stated she checked on him Sunday morning ([DATE]) and he was twitching and moaning. She asked the evening nurse if she had given him anything throughout the night. Staff F stated she told Staff G, RN to give him some pain meds and she would call hospice. Staff F told hospice he was actively dying. Hospice placed her on hold to locate a nurse in the area. Hospice office told Staff F that they were sending a nurse over. Staff F reported to the Hospice office that the resident had an order for Morphine, but it had not been given yet. Staff F informed Hospice office the morphine was being given now. Staff F stated the Hospice nurse called her and stated she would be at the facility in 15 minutes. Staff F told the Hospice nurse she would wait to assess the resident until she (hospice nurse) got there. Staff F stated later the CNA (Certified Nursing Assistant) told her the resident was gone. Staff F stated she grabbed his chart and checked his code status. He was a DNR. She checked him and he had no pulse or respirations. Staff F stated she called the hospice nurse back and informed her of his passing. The hospice nurse was just coming into the building. Staff F walked the hospice nurse to the room. The hospice nurse pronounced him expired and she let the team know. Staff F stated she did not know about the medication (morphine) error until after the fact. Staff F stated that when drawing up morphine we are to use syringes for small doses. Staff F stated, We are to check the orders to the medication. Once the nurses check the medication and order they check the order again. Staff F stated they need to check the dose again to make sure it is correct. Stated they are to check it is the right resident, right time, right route. Staff F stated the oncoming shift does the narcotic count with the off going shift. The narcotic sheets are to be checked to the medication in the cart. Staff F stated, we even check the empty cards. Staff F stated she did not know anything about a medication error. She stated the nurses started having education on medication pass and she heard it was because of Resident #4. Staff F stated as far as she knew Resident #4 was stable but actively dying. Staff F stated the aide told her he would do an occasional moan.<br><br>During an interview on [DATE] at 2:42 p.m. the Medical Director and /or Primary Provider MD stated the staff told her about the morphine missing. She stated that days later the DON stated she had spoken with the nurse that had worked with on the weekend and realized he (Resident #4) was given the wrong dosage. Medical Director stated Resident #4 was her resident. She stated he was elderly and on hospice. Medical Director stated, It was hard to say if the med (morphine) affected him or not. He was really declining. The Medical Director stated she spoke with Staff H, NP that Friday ([DATE]) and they said he was declining. The Medical Director stated she was informed he passed away. The Medical Director / Primary Provider MD stated, I am not able to say if the morphine error contributed to his death or not, hard to say. She stated, It was a high dose. She stated he was declining before the med error, difficult to contribute.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105644 | A. Building<br>B. Wing | 09/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aviata at Fletcher | 518 W Fletcher Ave<br>Tampa, FL 33612 |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility's policy titled, Physician Orders, revised [DATE] showed The center will ensure that physician orders are appropriately and timely documented in the medical record. Procedure: admission orders: information received from the referring facility for agency to be reviewed, verified with the physician and transcribed to the electronic medical record. The attending physician will review and confirm orders. Confirmation of admission orders requires that the physician sign and date the order during, or as soon as practicable after it is provided, to maintain an accurate medical record. Routine orders: A nurse may accept a telephone order from the physician, physician assistant or nurse practitioner. The order will be repeated back to the physician, PA or ARNP for his / her verbal confirmation. The order is transcribed to all appropriate areas of the electronic health record (eMAR / eTAR). For pharmacy orders, the nurse will notify the pharmacy per pharmacy policy by telephoning, faxing or completing the order electronically. The ordering physician or physician extender will review and confirm orders. Confirmation of routine orders requires that the physician sign and date to order as soon as practicable after it is provided to maintain an accurate medical record.<br><br>2. On [DATE] at 1:00 p.m , Resident #5 was observed lying down in bed with her call light within reach. She was observed with no signs of distress. She said approximately 2 weeks ago the nurse assigned to their room gave her, her roommate's medication and gave her roommate her medication. She said she did not have any negative effects, but she thought it was strange it happened. Resident #5 said she received 3 Tylenol tablets and 1 Gabapentin tablet.<br><br>Review of an admission Record dated [DATE] revealed Resident #5 originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include but not limited to unspecified open wound of abdominal wall, unspecified quadrant without penetration into peritoneal cavity, subsequent encounter, pressure ulcer of other site stage 3, nonrheumatic tricuspid (valve) insufficiency, nonrheumatic mitral (valve) insufficiency, cardiomyopathy, unspecified<br><br>Review of a Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status, (BIMS) summary score of 15, which indicated Intact cognitive abilities.<br><br>Review of physician order showed:<br><br>Acetaminophen tablet 325 milligram (MG), give 2 tablets by mouth every 6 hours as needed for pain, fever, order date [DATE]<br><br>Coreg Oral Tablet 3.125 MG (Carvedilol), give 1 tablet by mouth two times a day for hypertension, order date [DATE]<br><br>Gabapentin Oral capsule 30 milligram (MG) (Gabapentin) give 1 capsule by mouth three times a day for Nerve pain, order date [DATE]<br><br>Midodrine hydrochloride (HCl) oral tablet 10 milligram (MG) (Midodrine HCl) give 1 tablet by mouth three times a day for hypotension hold for systolic blood pressure 120, order date [DATE]<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105644 | A. Building<br>B. Wing | 09/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aviata at Fletcher | 518 W Fletcher Ave<br>Tampa, FL 33612 |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. On [DATE] at 1:00 p.m., Resident # 6 was observed sitting up in her wheelchair watching television and talking to her roommate. She was observed well-groomed with no signs of distress. Resident # 6 said their nurse came in the room and gave her roommate's medication to her. She said when the nurse gave her the medication, she took all the pills, but when she got to the last pill, she noticed it was not familiar. She said when she asked the nurse about the medication, the nurse realized she made a mistake and gave her and her roommate the wrong medication.<br><br>Review of Resident # 6 admission record dated [DATE] revealed she was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include but not limited to chronic obstructive pulmonary disease with (acute) exacerbation, type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy, peripheral vascular disease, unspecified polyarthritis, unspecified<br><br>Review of a Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 15 which indicated<br><br>Review of physician order showed<br><br>Acetaminophen tablet 325 milligram (MG), give 3 tablets by mouth every 8 hours as needed for pain, order date [DATE]<br><br>Gabapentin Oral tablet (Gabapentin) Give 3000 milligrams (MG) by Prescriber mouth every 8 hours for Nerve pain hold if sedated or confused, order date [DATE]<br><br>Zofran Oral Tablet 4 milligram (MG) Ondansetron Hydrochloride (HCl), give 1 tablet by mouth every 6 hours as needed for nausea and vomiting, order date [DATE]<br><br>Review of a nursing progress note dated [DATE] revealed, Nurse Practitioner was notified about medication error. Resident # 6 vital signs noted. Medical Doctor (MD) ordered to monitor blood pressure every hour notify MD regarding changes.<br><br>On [DATE] at 12:45 p.m., an interview was conducted with the Director of Nurses, DON. The DON said on [DATE] she received a phone call to inform her that the nurse gave Resident #5 her roommates medication and gave her roommate her medication. She said it was not clear on the incident report what medications were given to each resident, but she was made aware that it was during the 5 p.m. med pass. The DON said as she reviewed the incident report that Resident #5 received Resident # 6 Tylenol. The DON said as she continued to review the documentation, Resident # 6 incident report does not list the medication she was given at the time of the incident. The DON said her expectations are if there is a medication error the nurse should document the medication that was given to the residents, notify the MD and the family and follow any recommendation the physician may have.<br><br>On [DATE] at 1:00 p.m. an interview was conducted with Staff A, Registered Nurse, RN. Staff A said she was in the middle of med pass when someone approached her, and she got distracted. Staff A said she made a mistake and gave Resident her roommate's Tylenol, and gave Resident # 6 her roommates Midodrine, Amlodipine, and Gabapentin. Staff A said she did not notify Resident #5's provider about the incident because the resident already has a PRN (as needed) order for Tylenol, she just received it without her request.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105644 | A. Building<br>B. Wing | 09/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aviata at Fletcher | 518 W Fletcher Ave<br>Tampa, FL 33612 |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On [DATE] at 2:30 p.m., an interview was conducted with the Medical Director. The Medical Director said her expectation were nurses need to verify who they are giving medications to before the medications are administered.<br><br>Review of the facility's policy, Administering Medications, revised [DATE] showed Medications are administered in a safe and timely manner, and as prescribed. Policy interpretation and Implementation<br><br>1. Only persons licensed or permitted by the state to prepare, administer and document the administration of medication may do so.<br><br>2. The director of nursing services supervises and directs all personnel who administer medication and / or have related functions.<br><br>4. Medications are administered in accordance with prescriber orders, including any required time frames.<br><br>6. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training.<br><br>8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns.<br><br>9. The individual administering medications verifies the resident's identity before giving the resident his / her medications. Methods of identifying the resident include:<br><br>a. Checking identification band;<br><br>b. Checking for photograph attached to medical record; and<br><br>c. If necessary, verifying resident identification with other facility personnel.<br><br>10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.<br><br>23. As required or indicated for a medication, the individual administering the medication records is in the residence medical record:<br><br>a. the date and time the medication was administered;<br><br>b. The dosage;<br><br>c. The route of administration;<br><br>d. The injection site (if applicable);<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105644 | A. Building<br>B. Wing | 09/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aviata at Fletcher | 518 W Fletcher Ave<br>Tampa, FL 33612 |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | e. Any complaints or symptoms for which the drug was administered;<br><br>f. Any results achieved and when these results were observed; and<br><br>g. The signature and title of the person administering the drug.<br><br>Review of the facility's policy, Notification of Change in Condition, revised [DATE] showed The center to promptly notify the patient / resident, the attending physician, and the resident representative when there is a change in the status or condition. Procedure:<br><br>The nurse to notify the attending physician and resident representative when there is a (n):<br><br>Accident<br><br>Significant change in the patient / resident's physical, mental, or psychosocial status<br><br>Need to alter treatment significantly<br><br>New treatment<br><br>Discontinuation of a current treatment due to but not limited to:<br><br>Adverse consequences<br><br>Acute condition<br><br>Exacerbation of a chronic condition<br><br>The nurse to complete an evaluation of the Patient / Resident. Document evaluation in the medical record.<br><br>The nurse will contact the physician. In the event that the attending physician does not respond in a reasonable amount of time, the Medical Director may be contacted.<br><br>Notify the Patient / Resident and the resident representative of the change in condition. Documentation notification in the medical record.<br><br>Document resident / patient change and condition on a 24-hour report.<br><br>Complete SBAR as indicated. |