STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105644	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Fletcher	518 W Fletcher Ave 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure medical records were complete and accurate related to alleged incidents of abuse and neglect for three residents (#3, #8, #9) of five sampled residents.Findings included: On 01/07/2026 at 10:00 a.m. Resident #3 was observed sitting in his wheelchair in the hallway. He described an incident that had occurred during medication administration with the night nurse. He stated he knew his insulin orders and that he gets a fast-acting type of insulin. Resident #3 stated Staff A, RN (Registered Nurse), disagreed and told him, Don't tell me how to do my job. Staff A, told him, EXPLICIT. Resident #3 stated Staff A kept coming back and harassing him. The resident stated he reported the incident to the administration.Review of Resident #3's medical record revealed he was admitted on [DATE] with diagnoses included but not limited to osteomyelitis, diabetes, mood (affective) disorder, history of falling, hypertension, lymphedema, and acquired absence of left leg below knee.Review of the admissions Minimum Data Set (MDS) dated [DATE] showed Section C, Brief Interview for Minimum Status (BIMS) score of 15, meaning cognitively intact.Review of a psych progress note dated 12/19/25 revealed, Patient had a verbal incident with a staff member. At time of psychiatric evaluation, patient is calm and cooperative. He denies depression exacerbation, anxiety, irritability, suicidal ideation, or homicidal ideation. He reports no ongoing psychiatric distress related to the incident.During an interview on 01/07/26 at 2:45 p.m. the Nursing Home Administrator (NHA) stated on 12/16/25 the Director of Nursing (DON) had alerted her that they had a possible reportable. The NHA and floor nurse went to talk to Resident #3 who stated the nurse (Staff A) was disrespectful the night before. The resident stated he asked Staff A about the fast-acting insulin that night and again at 6 a.m. The resident said Staff A stated he did not have an order for it (fast acting insulin) and would have to check it after medication pass. The resident stated Staff A said, Don't tell me how to do my job. The resident said Staff A made comments about his mother. The resident said Staff A came back multiple times and he kept arguing with him. The resident stated he felt like Staff A was being verbally abusive. The NHA stated she interviewed the roommate who stated he did not remember specifics of the interchange between them, but Staff A was disrespectful and yelling. The NHA said the roommate said Staff A was the first to start yelling and came back multiple times yelling. The NHA stated she interviewed Staff A with Human Resource person present, and Staff A said Resident #3 did ask for the fast-acting insulin, and he did not give it because it was not correct. Staff A stated he checked the chart and Resident #3 did not have an order for fast acting insulin. The NHA verified that Staff A did give the fast-acting insulin based on the documentation on the MAR. Staff A told the NHA Resident #3 called him bad names. Staff A verified what he had said to the resident and said he told Resident #3, if you do not respect me, I will not respect you. Staff A stated he was not ever going to hit Resident #3. The NHA stated Staff A admitted he was wrong. The NHA stated based on the interview with Staff A, the (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: 105644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Aviata at Fletcher		STREET ADDRESS, CITY, STATE, ZIP CODE 518 W Fletcher Ave 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	allegation was substantiated because of calling names. The NHA stated Resident #3 was seen by psych on12/23/25. The NHA and the Nurse Consultant both stated there should have been documentation in the progress notes about the altercation with the resident. They stated the documentation needed was a progress note or a Situation, Background, Assessment, Recommendation (SBAR) which would include an assessment, and notification of needed parties. The NHA verified there was no documentation about the incident in the medical record.2. Resident #8 was admitted on [DATE] with diagnoses included but not limited to interstitial pulmonary diseases, Chronic Obstructive Pulmonary Disease, diabetes, asthma, cognitive communication deficit, depression, dialysis, Congestive Heart Failure, and hypertension. Review of the MDS dated [DATE] showed a BIMS score of 15, meaning the resident was cognitively intact.Review of a psych progress note for Resident #8 showed on 11/06/2025, the patient was seen at staff request following an episode of agitation during which he reportedly pushed another resident's walker. He is newly admitted for rehabilitation. Stated he has had a hard year but declines to elaborate and requested to stop the interview, stating he was becoming paranoid. Denies history of psychiatric treatment and declines medication for mood or anxiety at this time. Patient is not in need of additional referral or follow-up services.Review of Resident #8's medical record revealed there were no progress notes and no SBAR assessment was documented regarding the resident-to-resident incident on 11/06/2025.Review of the care plans showed there were no care plan updates related to the incident on 11/06/2025. 3. Resident #9 was admitted on [DATE] and readmitted on [DATE]. Review of the admission record showed diagnoses included but not limited to schizoaffective disorder, bipolar type, COPD, seizures, chronic pain, anxiety, depression, and hypertension. Review of the quarterly MDS dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 12 (moderately impaired).Review of a psych services progress note for Resident #9 showed on 11/11/2025, Pt (patient) was seen today for follow-up after a resident-to-resident incident in which she was bumped by another resident while in her wheelchair. Upon evaluation, the patient was calm, cooperative and showed no adverse effects from the incident. She denied any abuse or neglect, and no psychosocial distress or injuries were noted.Review of Resident #9's medical record revealed there were no progress notes and no SBAR assessment was documented regarding the resident-to-resident incident on 11/06/2025.During an interview on 01/07/2026 at 3:21 p.m. the Nursing Home Administrator (NHA) and the Nurse Consultant stated on 11/06/25 at 2:00 p.m. Resident #9 alleged that Resident #8 was hitting her wheelchair with his wheelchair and when Resident #9 asked Resident #8 to stop, Resident #8 said, I will do worse to you. The NHA stated the residents were separated immediately and placed on frequent monitoring. The NHA stated they were placed on different smoke breaks. The NHA stated the Activities Director stated Resident #9 was trying to go out to smoke and Resident #8 was sitting next to her and bumped into her with his wheelchair, like bumper cars. The NHA stated the other residents on the patio were interviewed. All the other residents but one denied hearing the incident. A resident witness said that Resident #8 was in line to get out the door for smoking and he bumped into Resident #9. The resident witness stated he heard Resident #8 say to Resident #9, I will do worse. The NHA stated they both self-propel their wheelchairs. The NHA stated that Resident #9 stated Resident #8 hit her wheelchair but never hit her. The NHA verified Resident #8 was seen by psych services on 11/06/2025. The NHA stated Resident #9 was seen by the medical provider on 11/06/2025 and had no behaviors or issues. The Nurse Consultant stated the expectation would be for the nursing staff to document a progress note, an assessment and/ or an SBAR in the medical record for the incident on 11/06/2025. The NHA reviewed Resident #8's medical record and found no documentation related to the 11/06/2025 incident, no progress note, no SBAR, no assessment and no care plan update. The NHA stated she would expect to find both the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Aviata at Fletcher		STREET ADDRESS, CITY, STATE, ZIP CODE 518 W Fletcher Ave 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation and a care plan update. The NHA reviewed Resident #9's medical record and found no documentation related to the 11/06/2025 incident, no progress note, no SBAR, and no assessment. The NHA stated she would expect to find documentation. The NHA stated there had not been any education provided to the nursing staff related to documentation post an incident, related to progress notes, SBAR, assessment, and updating the care plan. The NHA stated all incidents were discussed at morning meetings. The NHA stated all staff are made aware of incidents during the Abuse and Neglect education provided. The NHA stated that during the investigation, the medical record was reviewed for cognition, why the resident was admitted , diagnoses. The NHA stated they may not have looked at the progress notes for documentation of the incident. When asked the reportable showed the resident's progress notes were reviewed. The NHA verified she wrote that they were reviewed.Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation, revised 11/06/2022 showed It is inherent in the nature and dignity of each resident at the center that he / she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and / or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse.Definitions:Mental and Verbal Abuse: Mental Abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation for degradation. Verbal abuse may be considered a form of mental abuse.Verbal Abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance regardless of age ability to comprehend our disability.Mental and verbal abuse include, but are not limited to:Harassing a residentMocking, insulting, ridiculingYelling or hovering over a resident, with the intent of intimidateMonitoring of residents who may be at risk is the responsibility of all facility staff2. Training: Employee Obligation: All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights.3. Prevention: The center is committed to the prevention of abuse, neglect, misappropriation of resident property and exploitation.Preliminary investigation: Immediately opened an allegation of abuse or neglect, the suspect (s) shall be segregated from residents pending the investigation of the resident allegation.The nurse or Director of Nursing / designee shall perform and document a thorough nursing evaluation and notify the attending physician.An incident report shall be filled by the individual in charge you received the report in conjunction with the person who reported the abuse. The report shall be filed as soon as possible in order to provide the most accurate information in a timely fashion and submitted to the abuse coordinator.6. Protection: the resident will be evaluated for any signs of injury, including a physical exam and / or psychosocial assessment, as appropriate.Provide the resident with emotional support and counselling during and after the investigation, if needed.Review of the facility's policy, Plans of Care, revised 09/25/2017 showed Review, update and / or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completed of each OBRA MDS assessment, and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being.