STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105665	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at South Daytona	650 Reed Canal Rd South Daytona, FL 32119

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of facility records, the facility failed to ensure the residents' right to be free from neglect by failing to implement sufficient safeguards and supervision to prevent one (Resident #1) of five residents reviewed for Activities of Daily Living (ADL) care from an avoidable fall with subsequent fractures of the lower right femur (thigh bone) and right patella (kneecap). The facility failed to ensure that staff implemented care plan interventions specifying two-person assistance and the use of a mechanical lift during transfers for Resident #1. On April 22, 2026, one certified nursing assistant (CNA) attempted to transfer Resident #1 from her bed to her chair by using a stand-and pivot method rather than following the resident's care plan indicating the need for a mechanical lift and two staff members for transfers. The resident fell during the transfer and sustained right femur and patellar fractures.Any resident requiring two-person staff assistance during transfers was at risk. There were 19 residents who required two-person assistance and/or the use of a mechanical lift during transfers at the time of the survey.The facility's failure created a situation that caused a serious injury to Resident #1 and resulted in the determination of Immediate Jeopardy on May 18, 2026. The findings of Immediate Jeopardy were determined to have been corrected as of April 27, 2026.The findings include:Cross reference F0689A review of Resident #1's medical record revealed an initial admission date of 9/25/2025, with a re-entry on 4/30/2026 and subsequent discharge on [DATE]. The resident's diagnoses included nondisplaced unspecified condyle fracture of lower end of right femur (thigh bone), subsequence encounter for closed fracture with routine healing; unspecified fracture of right patella (kneecap), subsequent encounter for closed fracture with routine healing; cerebral palsy (a lifelong neurological disorder affecting a person's movement, muscle tone, balance and posture).A review of Resident #1's Change in Condition report, dated 4/22/2026 at 2:42 PM, revealed the resident had a fall. Recommendations included imaging of bilateral hip and pelvis, right femur, right knee, tibia/fibula (lower leg).A review of a nursing progress note, dated 4/22/2026 at 7:45 PM, revealed that per the physician's request, the portable x-ray provider was returning to the facility to re-take x-rays due to poor positioning. There were no further orders other than to continue pain management with hydrocodone (opioid pain reliever used to manage severe, persistent pain) 5/325 every six hours to keep the resident comfortable.A review of a nursing progress note dated 4/22/2026 at 8:13 PM revealed that the physician ordered the resident to be transferred to the hospital for further assessment due to inadequate imagery.A review of the hospital discharge paperwork, dated 4/30/2026, revealed that the resident was admitted on [DATE] at 8:30 PM with a chief complaint of knee pain in the back of her right knee, after the staff at her living facility were trying to transfer her but they were unable to support her weight, so she fell onto her knee. A knee CT (computed tomography) scan (imaging test using x-rays and computer processing to create detailed cross-sectional images of the inside of the body) was ordered and reviewed by the physician who confirmed a distal femur fracture.A review of Resident #1's active care plan, revised on 4/8/2026, revealed that the resident had an ADL (activities of daily living) self-care performance deficit related to a diagnosis of cerebral palsy. The care plan noted that the resident required (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	assistance as follows: All care to be provided by two staff. Bed mobility: The resident requires extensive assist of two staff for turn and reposition in bed as necessary. Transfer: The resident requires a Hoyer lift (mechanical lifting device used to transfer residents with limited mobility) with two staff assistance for transfers.A review of Resident #1's quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 3/18/2026, revealed that Resident #1 had a brief interview for mental status (BIMS) score of 14 out 15 possible points, indicating intact cognition. She was noted as dependent with toileting hygiene, bed mobility and transfers.A review of the facility's investigation of the 4/22/2026 event revealed a 4/23/2026 written statement provided by Certified Nursing Assistant (CNA) A, Resident #1's assigned CNA on 4/22/2026, that read, On the morning of April 22nd, I wasn't feeling well so I was doing my rounds slowly. Once I reached [Resident #1's] room, I noticed she hadn't been in the facility for a period of time. I initially attempted to locate a Hoyer lift pad but being unable to find the Hoyer pad and a sit-to-stand (lift) and based on my previous experience of successfully pivoting this resident to her chair, I proceeded to manual pivot transfer. During the transfer, the resident's weight shifted, and it was clear we would not reach the chair safely. To ensure her safety, I did not allow her to fall, I guided her slowly and controlled to the floor. The nurse was stationed outside the room, so I'm sure he would of heard something . back. I immediately called for the nurse, the nurse entered and attempted to assist me with lifting the resident, but due to her weight keep shifting, we were unable to complete the lift with two people. I then sought out a third coworker. Together the three of us successfully and safely assisted the resident into her chair. During the entire process and immediately following the assist, the resident did not express pain, showed no signs of physical or emotional distress, did not scream or call out.On 5/18/2026 at 1:45 PM, Resident #1 was observed lying in bed. She reported having been in the facility for almost a year, but she had been in and out, so she could not say exactly how long. When she was asked if she recently had a fall, she reported she did and had to wear this brace for another three weeks, as she pointed to her right leg. She stated at one time she used to sit and stand when she got in and out of a chair or her bed. When she came back from one of her hospital stays, she needed more help getting in and out of bed, so she used a sit-to-stand lift, but now they used a Hoyer lift with a sling. The day the incident occurred, CNA A came to get her out of bed and into her wheelchair. CNA A wrapped her arms around her body. She held me like a bear, and once she had me up, she couldn't hold on. We've done this before, but I guess she got tired because she dropped me, and when she tried to help me back up, she dropped me again, and I fell and my leg was caught underneath me, and I ended up with a break.On 5/19/2026 at 9:14 AM, an attempt to reach CNA A (who was no longer employed by the facility) by telephone was unsuccessful.On 5/19/2026 at 9:54 AM, an interview was conducted with the Interim Director of Clinical Services (IDCS). She reported coming in after the incident on the morning of 4/22/2026 to work the medication cart, and she was informed by Resident #1 that her knee was bothering her. The IDCS assessed Resident #1 and noted no swelling, shortness of leg or bruising, but she informed the resident that she would contact her physician. She administered pain medication and the portable x-ray provider was called with an order for bilateral hip pelvis, knee, femur and tib/fib (tibia/fibula - lower leg). Resident #1 pointed at her thigh but could not pinpoint the exact location of the pain. The portable x-ray provider arrived but was unable to get clear imaging due to Resident #1's positioning, and they were unable to repeat. The physician ordered Resident #1 to be transferred to the emergency room and there, CT imaging was completed and fractures were found. CNA A did not report the fall. The IDCS stated she was brought into it afterward to focus on staff education. All direct care CNAs and nursing staff were provided with education on how to complete proper transfers and how to utilize the Kardex (a quick-reference summary of the resident's medical history, care plans, and daily needs) in the computer that explains resident-specific transfer mobility status. She further stated this information was also available in the residents' physical chart at the nursing stations.On 5/19/2026 at 11:28 AM, an interview was conducted via telephone with Licensed Practical Nurse (LPN) B, who stated he was on the hall and (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	close to Resident #1's room when the fall occurred. He heard CNA A call for help. He entered the room and saw CNA A holding Resident #1 up on the side of the bed as she was slipping down. The resident's feet were on the floor. She was too heavy and the two of them could not get her back in bed. LPN B asked CNA A to get help from another CNA while he held the resident up. He stated, Another CNA and I, along with [CNA A], got her back in bed safely. Her [Resident #1's] transfer status is lift-to-stand or Hoyer lift, but both lifts require two staff. He confirmed that CNA A had worked with Resident #1 before. She [Resident #1] has been two staff assist since she's been at the facility; her legs don't hold her up too well. LPN B stated he asked CNA A if the resident had a fall, and she said, No, I'm just holding her here. He confirmed having participated in training on abuse and neglect, and proper resident transfers to include mechanical lifts, annually during skill competencies. He also received training and education on 4/23/2026 after Resident #1's 4/22/2026 incident. The education included safe transfer of a resident by utilizing the resident's Kardex to ensure proper transfer techniques. The education also included notifying the DCS immediately after a fall occurred, as well as Abuse and Neglect training. LPN B stated he was aware that Resident #1 returned to the facility with fractures and that they probably could have been avoided. He stated the expectations for CNAs was that they accessed/reviewed the care plans for their assigned residents, which explained each resident's needs, prior to and during provision of care. This was confirmed when the CNAs signed off on their assignments throughout the shift, so they all had access to their assigned residents' plans of care to include transfer needs.On 5/20/2026 at 12:18 PM in a follow-up interview with the IDCS, she stated the expectation for all CNAs at the start of their shift was that they got their assignments. There's a printed-out list of the aide assignments at the nurses' station, and the assignments are posted on the whiteboard. The oncoming CNA will get a report from the off-going CNA, and they will complete walking rounds together to discuss any changes/updates or notifications needed to provide care to their assigned residents for that shift. This is the expectation, and all CNAs are educated during new orientation, annually and incidentally. She confirmed that the 4/22/2026 incident involving Resident #1's fall with injury could have been avoided if the resident's care plan had been reviewed and followed prior to providing transfer assistance to Resident #1 from the bed to the chair. A review of the CNA Job Description revealed essential duties and responsibilities including:Purpose:The primary purpose of your job position is to provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan.Duties and Responsibilities:2. Participate in resident care assessments.3. Assist in development of resident treatment plans.4. Provide direct care in accordance with treatment plan.10. Act in accordance with all corporate, state, federal and other regulatory standards.31. Follow established safety precautions in the performance of all duties.43. Wear and/or use safety equipment and supplies (e.g. back brace, mechanical lift, etc.) when lifting or moving residents.A review of the facility's policy and procedure titled Abuse, Neglect, Exploitation and Misappropriation (revised 11/16/2022), revealed:Policy: 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.Definition:Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include but are not limited to;Failure to take precautionary measures to protect the health and safety of the resident.The facility's immediate actions to remove the Immediate Jeopardy included: The CNA involved in the incident was suspended on 4/22/2026, terminated on 4/30/2026, and was reported to the licensing board on 4/30/2026.An Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held on 4/23/2026 with the QAPI committee to review the incident, root cause analysis and plan to be implemented.On 4/23/2026, Abuse and Neglect education was initiated and completed by the Interim Director of Nursing (IDCS) for all facility staff regarding the abuse and neglect policy with 100% of staff having received the education as of 4/27/2026.Resident assessments were (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	initiated on 4/23/2026 by the IDCS to determine which residents required a mechanical lift for transfers, with a 100% resident review completed by 4/27/2026.A second Ad Hoc QAPI meeting was conducted on 4/28/2026 to review and report progress on the implemented plan. The root cause analysis was identified as initial transfer attempt without the use of a mechanical lift; staff failed to review or follow the care plan to transfer. No other residents were affected by the deficient practice; all components of the incident were addressed with substantial compliance as of 4/27/2026.The monitoring procedure to ensure that the removal plan was effective and remained corrected/in compliance with the regulatory requirements included:To remain in compliance and under the direction of the Administrator, beginning 4/28/2026:Initiated monitoring on 4/28/2026 by the NHA (Nursing Home Administrator) and DCS of new admissions/readmissions to ensure the baseline care plan is initiated with the appropriate transfer status.Initiated random observations on 4/28/2026 by the DCS and UM (Unit Manager) of staff during the transfer process to ensure proper technique is being used, along with randomly interviewing CNAs to ensure they can articulate the process for how to determine the residents' transfer status and where to locate the Kardex.Verification of the facility's removal plan was completed by the surveyor from 5/18/2026 through 5/20/2026.Interviews were conducted with 11 clinical staff members who worked across all shifts, as well as facility management, including the Interim Administrator, Interim Director of Nursing, Unit Managers, and Rehabilitation Director. Interviews revealed that staff were able to state they had been trained and were knowledgeable about facility policies and procedures regarding care plans, use of the Kardex, the definition of neglect, and the required number of staff needed when transferring a resident requiring a mechanical lift.Tours of the facility indicated that safe resident transfers and bed mobility assistance, using appropriate equipment and number of staff to assist, were in place.A review of in-service documentation revealed that 100% of staff had acknowledged education and training related to neglect, safe resident transfers and the process for reviewing the care plan/Kardex prior to transfer, in addition to skilled competencies regarding mechanical lifts for clinical staff.Based on verification of the facility's Immediate Jeopardy removal plan, the immediate jeopardy was determined to have been corrected as of 4/27/2026.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of facility records, the facility failed to implement sufficient safeguards and supervision to prevent one (Resident #1) of five residents reviewed for Activities of Daily Living (ADL) care from an avoidable fall with subsequent fractures of the lower right femur (thigh bone) and right patella (kneecap). The facility failed to ensure that staff implemented care plan interventions specifying two-person assistance and the use of a mechanical lift during transfers for Resident #1. On April 22, 2026, one certified nursing assistant (CNA) attempted to transfer Resident #1 from her bed to her chair by using a stand-and pivot method rather than following the resident's care plan indicating the need for a mechanical lift and two staff members for transfers. The resident fell during the transfer and sustained right femur and patellar fractures.Any resident requiring two-person staff assistance during transfers was at risk. There were 19 residents who required two-person assistance and/or the use of a mechanical lift during transfers at the time of the survey.The facility's failure created a situation that caused a serious injury to Resident #1 and resulted in the determination of Immediate Jeopardy on May 18, 2026. The findings of Immediate Jeopardy were determined to have been corrected as of April 27, 2026.The findings include:Cross reference F0600A review of Resident #1's medical record revealed an initial admission date of 9/25/2025, with a re-entry on 4/30/2026 and subsequent discharge on [DATE]. The resident's diagnoses included nondisplaced unspecified condyle fracture of lower end of right femur (thigh bone), subsequence encounter for closed fracture with routine healing; unspecified fracture of right patella (kneecap), subsequent encounter for closed fracture with routine healing; cerebral palsy (a lifelong neurological disorder affecting a person's movement, muscle tone, balance and posture).A review of Resident #1's Change in Condition report, dated 4/22/2026 at 2:42 PM, revealed the resident had a fall. Recommendations included imaging of bilateral hip and pelvis, right femur, right knee, tibia/fibula (lower leg).A review of a nursing progress note, dated 4/22/2026 at 7:45 PM, revealed that per the physician's request, the portable x-ray provider was returning to the facility to re-take x-rays due to poor positioning. There were no further orders other than to continue pain management with hydrocodone (opioid pain reliever used to manage severe, persistent pain) 5/325 every six hours to keep the resident comfortable.A review of a nursing progress note dated 4/22/2026 at 8:13 PM revealed that the physician ordered the resident to be transferred to the hospital for further assessment due to inadequate imagery.A review of the hospital discharge paperwork, dated 4/30/2026, revealed that the resident was admitted on [DATE] at 8:30 PM with a chief complaint of knee pain in the back of her right knee, after the staff at her living facility were trying to transfer her but they were unable to support her weight, so she fell onto her knee. A knee CT (computed tomography) scan (imaging test using x-rays and computer processing to create detailed cross-sectional images of the inside of the body) was ordered and reviewed by the physician who confirmed a distal femur fracture.A review of Resident #1's active care plan, revised on 4/8/2026, revealed that the resident had an ADL (activities of daily living) self-care performance deficit related to a diagnosis of cerebral palsy. The care plan noted that the resident required assistance as follows: All care to be provided by two staff. Bed mobility: The resident requires extensive assist of two staff for turn and reposition in bed as necessary. Transfer: The resident requires a Hoyer lift (mechanical lifting device used to transfer residents with limited mobility) with two staff assistance for transfers.A review of Resident #1's quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 3/18/2026, revealed that Resident #1 had a brief interview for mental status (BIMS) score of 14 out 15 possible points, indicating intact cognition. She was noted as dependent with toileting hygiene, bed mobility and transfers.A review of the facility's investigation of the 4/22/2026 event revealed a 4/23/2026 written statement provided by Certified Nursing Assistant (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(CNA) A, Resident #1's assigned CNA on 4/22/2026, that read, On the morning of April 22nd, I wasn't feeling well so I was doing my rounds slowly. Once I reached [Resident #1's] room, I noticed she hadn't been in the facility for a period of time. I initially attempted to locate a Hoyer lift pad but being unable to find the Hoyer pad and a sit-to-stand (lift) and based on my previous experience of successfully pivoting this resident to her chair, I proceeded to manual pivot transfer. During the transfer, the resident's weight shifted, and it was clear we would not reach the chair safely. To ensure her safety, I did not allow her to fall, I guided her slowly and controlled to the floor. The nurse was stationed outside the room, so I'm sure he would of heard something . back. I immediately called for the nurse, the nurse entered and attempted to assist me with lifting the resident, but due to her weight keep shifting, we were unable to complete the lift with two people. I then sought out a third coworker. Together the three of us successfully and safely assisted the resident into her chair. During the entire process and immediately following the assist, the resident did not express pain, showed no signs of physical or emotional distress, did not scream or call out.On 5/18/2026 at 1:45 PM, Resident #1 was observed lying in bed. She reported having been in the facility for almost a year, but she had been in and out, so she could not say exactly how long. When she was asked if she recently had a fall, she reported she did and had to wear this brace for another three weeks, as she pointed to her right leg. She stated at one time she used to sit and stand when she got in and out of a chair or her bed. When she came back from one of her hospital stays, she needed more help getting in and out of bed, so she used a sit-to-stand lift, but now they used a Hoyer lift with a sling. The day the incident occurred, CNA A came to get her out of bed and into her wheelchair. CNA A wrapped her arms around her body. She held me like a bear, and once she had me up, she couldn't hold on. We've done this before, but I guess she got tired because she dropped me, and when she tried to help me back up, she dropped me again, and I fell and my leg was caught underneath me, and I ended up with a break.On 5/19/2026 at 9:14 AM, an attempt to reach CNA A (who was no longer employed by the facility) by telephone was unsuccessful.On 5/19/2026 at 9:54 AM, an interview was conducted with the Interim Director of Clinical Services (IDCS). She reported coming in after the incident on the morning of 4/22/2026 to work the medication cart, and she was informed by Resident #1 that her knee was bothering her. The IDCS assessed Resident #1 and noted no swelling, shortness of leg or bruising, but she informed the resident that she would contact her physician. She administered pain medication and the portable x-ray provider was called with an order for bilateral hip pelvis, knee, femur and tib/fib (tibia/fibula - lower leg). Resident #1 pointed at her thigh but could not pinpoint the exact location of the pain. The portable x-ray provider arrived but was unable to get clear imaging due to Resident #1's positioning, and they were unable to repeat. The physician ordered Resident #1 to be transferred to the emergency room and there, CT imaging was completed and fractures were found. CNA A did not report the fall. The IDCS stated she was brought into it afterward to focus on staff education. All direct care CNAs and nursing staff were provided with education on how to complete proper transfers and how to utilize the Kardex (a quick-reference summary of the resident's medical history, care plans, and daily needs) in the computer that explains resident-specific transfer mobility status. She further stated this information was also available in the residents' physical chart at the nursing stations.On 5/19/2026 at 11:28 AM, an interview was conducted via telephone with Licensed Practical Nurse (LPN) B, who stated he was on the hall and close to Resident #1's room when the fall occurred. He heard CNA A call for help. He entered the room and saw CNA A holding Resident #1 up on the side of the bed as she was slipping down. The resident's feet were on the floor. She was too heavy and the two of them could not get her back in bed. LPN B asked CNA A to get help from another CNA while he held the resident up. He stated, Another CNA and I, along with [CNA A], got her back in bed safely. Her [Resident #1's] transfer status is lift-to-stand or Hoyer lift, but both lifts require two staff. He confirmed that CNA A had worked with Resident #1 before. She [Resident #1] has been two staff assist since she's been at the facility; her legs don't hold her up too well. LPN B stated he asked CNA A if the resident had a fall, and she said, No, I'm just holding her here. He confirmed having (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	participated in training on abuse and neglect, and proper resident transfers to include mechanical lifts, annually during skill competencies. He also received training and education on 4/23/2026 after Resident #1's 4/22/2026 incident. The education included safe transfer of a resident by utilizing the resident's Kardex to ensure proper transfer techniques. The education also included notifying the DCS immediately after a fall occurred, as well as Abuse and Neglect training. LPN B stated he was aware that Resident #1 returned to the facility with fractures and that they probably could have been avoided. He stated the expectations for CNAs was that they accessed/reviewed the care plans for their assigned residents, which explained each resident's needs, prior to and during provision of care. This was confirmed when the CNAs signed off on their assignments throughout the shift, so they all had access to their assigned residents' plans of care to include transfer needs.On 5/20/2026 at 12:18 PM in a follow-up interview with the IDCS, she stated the expectation for all CNAs at the start of their shift was that they got their assignments. There's a printed-out list of the aide assignments at the nurses' station, and the assignments are posted on the whiteboard. The oncoming CNA will get a report from the off-going CNA, and they will complete walking rounds together to discuss any changes/updates or notifications needed to provide care to their assigned residents for that shift. This is the expectation, and all CNAs are educated during new orientation, annually and incidentally. A review of the facility's policy and procedure titled Plans of Care (Effective: 11/30/14, Revised: 9/25/2017), revealed:An individual person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal requirements. Plan of care is to be maintained as part of the final medical record.Procedure:Develop and implement an individualized person-centered baseline plan of care within 48 hours of admission that includes, but is not limited to, initial goals based on the admission orders, physician's orders, dietary orders, therapy services, social services, PASRR recommendations, if applicable, and other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs are met appropriately until the Comprehensive plan of care is completed.Develop and implement an individualized person-centered comprehensive plan of care by the interdisciplinary team that includes but is not limited to, the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident, and, to the extent practicable, the participation of the resident and the resident's representative(s) within seven (7) days of completion of the comprehensive assessment.A review of the facility's policy and procedure titled Transfer/Mobility Evaluation Low Lift (Effective: 11/30/2014, Revised: 11/2/2025), revealed:Center will evaluate the transfer and lifting needs of the resident to safely and comfortably transfer according to their individualized needs.Procedure:3. Two staff members are required when using a mechanical lift.4. Lift status will be indicated on the resident's care plan and Kardex.The facility's immediate actions to remove the Immediate Jeopardy included: The CNA involved in the incident was suspended on 4/22/2026, terminated on 4/30/2026, and was reported to the licensing board on 4/30/2026.An Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held on 4/23/2026 with the QAPI committee to review the incident, root cause analysis and plan to be implemented.Resident assessments were initiated on 4/23/2026 by the IDCS to determine which residents required a mechanical lift for transfers, with a 100% resident review completed by 4/27/2026.On 4/23/2026, clinical staff training was initiated by the IDCS for safe transfers, the process to review the care plan/Kardex prior to completing resident transfers, and the process for reporting a resident's fall. 100% of clinical staff received the education by 4/27/2026. Education was validated using a post test. Clinical staff were not permitted to work until the education was received.Competencies for the proper use of mechanical lifts were initiated on 4/23/2026 by the IDCS for licensed nurses and certified nursing assistants. 100% of nurses and CNAs completed competencies as of 4/27/2026.A second Ad Hoc QAPI meeting was conducted on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105665	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at South Daytona	650 Reed Canal Rd South Daytona, FL 32119

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	4/28/2026 to review and report progress on the implemented plan. The root cause analysis was identified as initial transfer attempt without the use of a mechanical lift; staff failed to review or follow the care plan to transfer. No other residents were affected by the deficient practice; all components of the incident were addressed with substantial compliance as of 4/27/2026.The monitoring procedure to ensure that the removal plan was effective and remained corrected/in compliance with the regulatory requirements included:To remain in compliance and under the direction of the Administrator, beginning 4/28/2026:Initiated monitoring on 4/28/2026 by the NHA (Nursing Home Administrator) and DCS of new admissions/readmissions to ensure the baseline care plan is initiated with the appropriate transfer status.Initiated random observations on 4/28/2026 by the DCS and UM (Unit Manager) of staff during the transfer process to ensure proper technique is being used, along with randomly interviewing CNAs to ensure they can articulate the process for how to determine the residents' transfer status and where to locate the Kardex.Verification of the facility's removal plan was completed by the surveyor from 5/18/2026 through 5/20/2026.Interviews were conducted with 11 clinical staff members who worked across all shifts, as well as facility management, including the Interim Administrator, Interim Director of Nursing, Unit Managers, and Rehabilitation Director. Interviews revealed that staff were able to state they had been trained and were knowledgeable about facility policies and procedures regarding care plans, use of the Kardex, the definition of neglect, and the required number of staff needed when transferring a resident requiring a mechanical lift.Tours of the facility indicated that safe resident transfers and bed mobility assistance, using appropriate equipment and number of staff to assist, were in place.A review of in-service documentation revealed that 100% of staff had acknowledged education and training related to safe resident transfers and the process for reviewing the care plan/Kardex prior to transfer, in addition to skilled competencies regarding mechanical lifts for clinical staff.Based on verification of the facility's Immediate Jeopardy removal plan, the immediate jeopardy was determined to have been corrected as of 4/27/2026.