

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105665	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Aviata at South Daytona		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, facility record review, and a review of facility policies and procedures, the facility failed to ensure it provided a clean, comfortable and homelike environment in four (Rooms #7, #8, #12 and #16) of 30 sampled rooms. The findings include: 1. On 08/11/25 at 11:07 AM, room [ROOM NUMBER] was observed and the bottom portion of the window was missing and covered with a large piece of wood and duct tape. On 08/11/25 at 11:11 AM, room [ROOM NUMBER]'s wall was observed with missing drywall and chipped paint. On 08/11/25 at 11:15 AM, room [ROOM NUMBER] was observed with a wall unit air conditioner missing the control knob and a 3 foot by 2-foot area adjacent to the wall air conditioner unit covered with chipped and bubbling paint. The door frame adjacent to the bathroom door was observed with rotting wood and chipped paint. Several baseboards in the room were missing paint. On 08/14/25 at 9:35 AM, a second observation was made of room [ROOM NUMBER] and the bottom portion of window was missing and covered with a large piece of wood and duct tape. On 08/14/25 at 9:40 AM, a second observation was made of room [ROOM NUMBER]'s wall with missing drywall and chipped paint. On 08/14/25 at 9:48 AM, a second observation was made of room [ROOM NUMBER] with a wall unit air conditioner missing the control knob and a 3 foot by 2 foot area adjacent to the wall air conditioner unit covered with chipped and bubbling paint. The door frame adjacent to the bathroom door was observed with rotting wood and chipped paint. Several baseboards in the room were missing paint. A review of the previous three months of TELS (maintenance computer program) work orders revealed no documentation of work orders related to a broken window adjacent to a window air conditioner unit, bathroom door frames, baseboards or chipped paint in rooms. On 08/14/2025 at 1:25 PM, an interview was conducted with Certified Nursing Assistant (CNA) A who reported that she had worked in the facility for three months. If she noticed an environmental problem, such as a rotting door frame or chipped paint in a resident's room, she would go into the Relias system (computer program) and make a maintenance request. She would also make a verbal request with the Maintenance Director. On 08/14/2025 at 1:31 PM, an interview was conducted with Licensed Practical Nurse (LPN) B who (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: 105665	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Aviata at South Daytona		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported she had worked at the facility for one year. She explained that if she noticed an environmental concern, such as a broken window with a wood board cover, she would call the Maintenance Director's cell phone and put a work order request in the TELS system, which went to the Maintenance Director's phone. On 08/14/25 at 2:13 PM, an interview was conducted with the Maintenance Director who reported he had worked in the facility since 11/4/25. He explained that there was no specific plan or calendar for the repair work in resident rooms. Every Friday he met with the Resident Experience Director, and they discussed which rooms repair work will be completed in. Repair work varied because some residents could not walk, and it would take longer to evacuate those rooms to make repairs and repaint the entire room. The Maintenance Director reported that he could paint an entire resident room in six hours. Sometimes other issues took priority, such as a burst pipe, and would interrupt renovation plans. He explained that he had been working on building renovations for the last seven months and had renovated 23 areas of the facility. The process to receive work orders for repair work included information received through angel rounds assigned to managers and conducted daily. Angel rounds included visually inspecting resident rooms and providing an angel rounds report issue identified during the daily morning meeting. He also received work order requests from staff through the TELS system. On 08/15/25 at 1:57 PM, the Maintenance Director verified the observations made in rooms #7, #8 and #12. A review of facility daily angel rounds conducted between 08/04/25 and 08/14/25 documented rooms #7, #8 and #12 were observed for areas including: floor free of holes or tears or stains and walls are in good repair (no unpainted areas or holes in the walls). Daily angel rounds conducted between 08/04/25 and 08/14/25 for rooms #7, #8 and #12 were checked as meeting angel round requirements. 2. On 8/12/25 at 11:06 AM, Resident #59 (room [ROOM NUMBER]) was awake and engaged with the surveyor. His bathroom was observed with no paper towels; the floor tile was heavily stained; tiles and grout were unattached from the wall above the sink; there was a leaking pipe under the sink that had a trash container catching water; there was water pooled at the threshold of bathroom door, and an unpleasant odor was detected. (Photographic evidence obtained) On 8/13/2025 at 10:44 AM, Resident #59's bathroom was observed with the floor tile heavily stained; tiles and grout were unattached from the wall above the sink; a leaking pipe under the sink had a trash container catching water; a piece of bed linen was on the floor, soaked and wet; water was pooled at the threshold of bathroom door, and an unpleasant odor was detected. (Photographic evidence obtained) On 8/14/2025 at 1:55 PM, an interview was conducted with Resident #59. He was asked if he could remember how long his bathroom floor had been flooding. He stated, It's been at least six days that it has been like that; it's about time somebody came to fix it. On 8/14/2025 at 2:25 PM, an interview was conducted with the Maintenance Director. He was asked about the condition of Resident #59's bathroom. He acknowledged that the sink pipes had been leaking on the floor. He explained that the leak occurred this week due to the resident sitting on the sink and causing the sink to detach from the wall. He was asked what the plan was for repair. He stated, I have a plumber in there now making repairs. He was asked what the plan was for other needed repairs around the facility. He stated, I don't have a written plan, the Resident Experience (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105665	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Aviata at South Daytona		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director (RED), Admissions and I get together every Friday and discuss which residents can be moved so that we can repair the walls and paint. We plan to change the color of the paint all over the building. We have been doing this for the last seven months and to date, 23 areas including resident rooms and the common area have been completed. It's difficult to plan ahead because moving residents involves several considerations. He was asked how other needed repairs were identified throughout the facility while they were doing these projects. He stated, We use Angel Rounds. Every day each manager has 2-3 rooms to check for any needed repairs, call light placement, privacy curtains and things like that. We can't repair anything unless it's entered in TELS. Even if we see it, it still has to be entered in TELS, and all the staff have access to TELS. He was asked how the Angel Rounds were documented. The Maintenance Director provided a form the facility used to document Angel Rounds. The documentation was requested for 8/7/25 through 8/14/25. The Angel rounds were provided and did not indicate any of the repairs needed that were identified in Resident #59's bathroom (room [ROOM NUMBER]). A review of the facility's policy and procedure titled Maintenance (Effective Date: 11/30/2014), Document Name: M-200 revealed: Policy: The facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair. Procedure: The Director of Environmental Services will follow all policies regarding routine periodic maintenance. The Director of Environmental Services will perform daily rounds of the building to ensure the plant is free of hazards and in proper physical condition. All employees will report physical plant areas or equipment in need of repair or service to their supervisor.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105665	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Aviata at South Daytona		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on a main nursing station refrigerator observation, facility documentation, staff interviews, and facility policy and procedure review, the facility failed to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness, with the potential to affect more than a limited number of residents who consumed foods from the facility, by failing to properly monitor and log temperatures of the main nursing station refrigerator. Unsafe food handling practices represent a potential source of pathogen exposure. The findings include: A follow-up tour was conducted on 08/13/2025 at 11:05 AM. During the tour, it was observed that temperatures were not accurately monitored for the refrigerator at the main nursing station where resident supplements were stored. Temperature documentation was missing for August 2025. (Photographic evidence obtained) An interview was conducted on 08/13/2025 at 12:17 PM with Registered Nurse (RN)/Infection Preventionist M. When asked who was responsible for checking and logging temperatures for the main nursing station refrigerator, she stated nursing was responsible for logging those temperatures. An interview was conducted on 08/14/2025 at 10:33 AM with Cook/Aide I who stated the process for providing snacks and supplements to residents was to transport snacks on the cart to the dining room. Certified nursing assistants (CNAs) and nurses passed snacks from the cart to residents in the dining room and resident rooms. Med pass supplements and applesauce were maintained in the refrigerator at the main nursing station. When asked who was responsible for logging temperatures for the nourishment refrigerator at the main nursing station, Cook/Aide I replied, the CDM (certified dietary manager). An interview conducted on 08/14/2025 at 10:40 AM with [NAME] J revealed that snack carts were provided to residents twice a day; at 2:00 PM and 8:00 PM. Applesauce and med pass supplements were stored in the mini refrigerator at the main nursing station. When asked who was responsible for logging temperatures for the nourishment refrigerator at the main nursing, station, [NAME] J replied, the dietary aide. On 08/14/2025 at 10:42 AM the CDM confirmed that the process for providing snacks and supplements to residents was that snacks were prepared for residents and were transported on the cart to the dining room or nursing station. The snack cart consisted of hot coffee, tea, juice, cups, snacks and supplements. Snacks were provided to residents at 10:00 AM, 2:00 PM, and 8:00 PM. Supplements were stored in an ice bath on the cart and med pass supplements and applesauce were stored in the mini refrigerator at the main nursing station. The CNAs or nurses logged refrigerator temperatures and Dietary staff checked for signatures/initials when restocking the refrigerator, usually daily. A review of the facility's policy and procedure titled Food Storage: Cold Foods, HCSG Policy 019 (dated 8/2022) revealed: Policy Statement: All time/temperature control for safety (TCS foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines for the FDA Food Code. Procedures: 4. An accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures will be recorded. (Copy obtained)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105665	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Aviata at South Daytona		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, facility document review, and the facility Policy and Procedure, the facility failed to ensure the Pharmacist Medication Regimen Reviews were maintained and carried out to minimize or prevent adverse consequences, to the extent possible for two (Residents #4 and #43) of five residents reviewed in a total survey sample of 30 residents. The findings include: 1.A review of Resident #4's Consultant Pharmacist Medication Regimen Review, dated 2/18/2025, revealed a recommendation made by consultant pharmacist: Need behavior monitoring added to electronic Medication Administration Record (eMAR) while on Trazodone and Zolof. Another review dated 7/10/2025, included a recommendation to please add behavior monitoring to eMAR while on Trazodone and Sertraline. (Copies obtained) A review of Resident #4's active physician's orders included trazodone HCl (hydrochloride) oral tablet 100 mg (milligrams), give 200 mg by mouth at bedtime related to major depressive disorder, recurrent, unspecified (F33.9) (dated 7/16/2025), Sertraline HCl oral tablet 100 mg, give 1 tablet by mouth at bedtime for depression (dated 5/28/2025), Eliquis oral tablet 5 mg (Apixaban), give 1 tablet by mouth two times a day for clot prevention (dated 5/22/2025), check for bleeding and bruising every shift for monitoring (dated 5/22/2025), Lasix oral tablet 40 mg (Furosemide), give 0.5 tablet by mouth one time a day for CHF (congestive heart failure) (dated 5/31/2025), Spironolactone oral tablet 25 mg, give 1 tablet by mouth one time a day for CHF (dated 5/22/2025). Other orders included a pain assessment every shift (dated 5/21/25). A medical record review revealed that Resident #4 was admitted to the facility on [DATE]. Her diagnoses included generalized anxiety disorder, coagulation deficit- unspecified, and major depressive disorder. A review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident was receiving antidepressant medication and had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 possible points, indicating intact cognition. The care plan, focus, goals, and interventions related to Resident #4 included the requirement to monitor for behaviors and side effects. 2.A review of Resident #43's Consultant Pharmacist Medication Regimen Review, dated 3/23/2025, revealed a recommendation made by consultant pharmacist: Need behavior monitoring added to electronic Medication Administration Record (eMAR) while on Depakote and Ativan. A review dated 4/7/2025 included a recommendation: Need behavior monitoring added to the eMAR while on Depakote, Ativan, and Trazodone. A review dated 5/12/2025 included a recommendation: Need behavior monitoring added to the eMAR while on Trazodone, Depakote, and Ativan. A review dated 5/12/2025 included a recommendation: Need behavior monitoring added to the eMAR while on Lorazepam and Mirtazapine, and a review dated 7/10/2025 included a recommendation: Need behavior monitoring added to eMAR while on Trazodone, Depakote, Lorazepam and Mirtazapine. (Copy obtained) A review of Resident #43's active physician's orders included Depakote Sprinkles oral capsule delayed release sprinkle 125 mg (Divalproex Sodium), give 250 mg by mouth three times a day related to persistent mood [affective] disorder (dated 3/12/2025); Trazodone HCl oral tablet 50 mg, give 50 mg by mouth at bedtime related to major depressive disorder, (dated 3/31/2025); Mirtazapine oral tablet 7.5 mg, give 1 tablet by mouth at bedtime for depression-related appetite loss (dated 5/7/2025); Lorazepam oral tablet 0.5 mg, give 0.5 tablet by mouth every 12 hours for anxiety related to generalized anxiety disorder, hold for lethargy (dated 6/4/2025); Side effects use - Mirtazapine every shift for monitoring (dated 6/26/2025); Side effects use - Lorazepam every shift for monitoring (dated 6/26/2025); Enhanced barrier precautions due to wound (dated 3/27/2025), and advance directives: do not resuscitate (dated 6/17/2025). Further review of the medical record revealed that Resident #43 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, persistent mood (affective) disorder; other specified personal risk factors, not elsewhere classified; generalized anxiety disorder; and unspecified dementia, unspecified severity, with mood disturbance. A review of (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105665	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Aviata at South Daytona		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Quarterly MDS, dated [DATE], revealed the resident was receiving antidepressant, opioid, and anticonvulsant medication, and had a Brief Interview for Mental Status (BIMS) score of 4/15, indicating severe cognitive impairment. The care plan, focus and goals related to resident #43 included impaired cognitive function/dementia or impaired thought processes related to dementia and use of antidepressant medications. Interventions included administering medications as ordered, anticipate and meet Resident #43's needs, and monitor/document for side effects and effectiveness. On 7/11/2025 at 1:00 AM, an encounter progress note revealed that Resident #43 was doing well overall. She was receiving psych meds with a gradual dose reduction (GDR) considered. Based on history, the resident was not able to tolerate a GDR and would likely become unstable (exacerbation of underlying psychiatric disorders that are mentioned in the diagnosis section) if medications were reduced. Tapering down the medication would not achieve the desired therapeutic effect; therefore, the resident is on minimal effective dosages of psychotropic medications to maintain or improve the patient's function, well-being, safety, and quality of life. GDR is therefore contraindicated and so GDR was not performed. On 8/13/2025 at 2:45 PM, an interview was conducted with Licensed Practical Nurse (LPN) L and Registered Nurse (RN)/Infection Preventionist M. LPN L verified that Resident #4 was receiving Trazodone, Zolof/sertraline, Lasix, and Spironolactone. When asked, how did she document behavior monitoring for residents on antidepressants. She replied, observe behavior. She also stated there was no documentation on the TAR (treatment administration record) for resident behaviors and there was no documentation of monitoring for diuretic use. On 8/13/2025 at 3:06 PM, RN N, Interim Director of Nursing (DON) confirmed that DON/ADON (assistant DON) was responsible for updating pharmacy medication regimen reviews. Pharmacy emailed reviews to the facility and the DON/ADON reviewed the recommendations. Pharmacy recommendations were delegated as appropriate. Medication changes were logged, and the sheets were placed in the binder. The DON/ADON followed up to ensure the tasks were completed, and the nursing staff added the orders in the computer for the residents to be monitored. On 8/13/2025 at 5:21 PM, LPN L was asked to verify Resident #43's documented behavior monitoring for Trazodone and Depakote. She confirmed that there was no documented monitoring for Trazodone and Depakote.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105665	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Aviata at South Daytona		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and policy and procedure review, the facility failed to ensure staff followed the facility's infection prevention and control program (IPCP) and adhered to isolation precautions for one (Resident #8) of six residents who were positive for COVID-19, by entering the resident's room without donning the required personal protective equipment (PPE) and transporting the resident without a mask to a common area, exposing other residents to COVID-19. The findings include: On 08/11/25 at 1:00 PM, upon entry to the facility, staff notified the survey team of an outbreak of COVID-19 with six of a census of 59 residents positive for COVID-19. On 08/11/25 at 2:08 PM, Certified Nursing Assistant (CNA) C was observed exiting Resident #8's room wearing only a surgical mask. Resident #8's door had droplet precaution signage and a fully stocked personal protective equipment (PPE) cart in the hallway adjacent to the door. CNA C reported that she had worked as a CNA at the facility since January of 2025. When she was asked what the facility's policy was for entering a room under droplet precautions, she replied that Resident #8 had COVID-19, and she entered the room to help Resident #8 turn on a movie on his phone. She admitted she should have worn full PPE, which consisted of a gown, an N95 mask, and gloves. On 08/11/25 at 3:30 PM, CNA D was observed transferring Resident #8 in a Geri chair (mobile recliner) from his room to the common dining/activities room. The resident was not wearing a mask. On 08/11/25 at 3:42 PM, Resident #8 was observed in the common dining/activities room not wearing a mask. Eight residents in the dining/activities room were within close proximity to Resident #8. On 08/11/25 at 3:43 PM, Resident #8 was interviewed while in the dining/activities room and stated he knew that he should be wearing a mask. He asked for a mask. A surgical mask obtained from the nursing station was provided to the resident. On 08/11/25 at 4:15 PM, CNA D was interviewed and reported that she had worked at the facility since May 2025. She explained that Resident #8 was diagnosed with COVID-19 about seven days ago. She stated she did not place a mask on Resident #8 while transferring him through the facility to the main dining/activities room because he did not like wearing a mask. She further explained that she transferred Resident #8 to the main dining/activities area because he was at risk for falls and having him nearby would allow the staff to keep a close eye on him. On 08/11/25 at 4:26 PM, Registered Nurse (RN) E was interviewed and reported she had worked at the facility since September of 2024. She explained that the facility's policy for residents diagnosed with COVID-19 should immediately be placed on isolation and droplet precautions should be initiated for the COVID-19-positive resident's room. Isolation for a positive COVID-19 resident was 10 days. She was not sure if the facility's policy noted whether or not a COVID-19-positive resident could leave their room during that time. On 08/11/25 at 4:40 PM, an interview was conducted with the facility's Infection Preventionist (IP)/Registered Nurse (RN). She explained that positive COVID-19 residents must be quarantined in their rooms for 10 days and were not permitted to leave their rooms during that time unless it was medically necessary. If that was the case, they were to wear a mask when outside of their rooms. She said Resident #8 was positive for COVID-19. She observed and verified that Resident #8 was in (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105665	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Aviata at South Daytona		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the common dining/activities room without a mask. On 08/11/25 at 4:45 PM, the IP/RN reported that she informed staff assigned to Resident #8 that the resident could not remain in the dining/activities room without wearing a mask and should be taken back to his room. She further explained that she instructed staff assigned to Resident #8 that because he was at risk for falls, he must be provided 1:1 (one-on-one) supervision while in his room. On 08/12/25 at 10:27 AM, the IP/RN stated staff entering rooms of residents who were positive for COVID-19 should perform hand hygiene and must don personal protective equipment (PPE), including an N95 mask, gown, eye protection and gloves prior to entering the room. Normally, residents on droplet precautions had a trash bag in the room or directly outside of the room for staff to dispose of used PPE. The facility was following CMS (Centers for Medicare and Medicaid Services) and the local Health Department's recommendations for isolation of COVID-19-positive residents for 10 days. On 08/14/25 at 3:40 PM, an interview was conducted with the Assistant Director of Nursing (ADON), who was acting as the interim Director of Nursing (DON). She reported that she had worked for the facility since 07/15/25. She explained that when residents were placed on contact precautions, staff must wear a gown, N95 mask and gloves when entering the resident's room. She further explained that residents diagnosed with COVID-19 must be on isolation precautions for 10 days and should not leave their rooms unless medically necessary. If they had to leave their rooms, a mask, preferably an N95 mask, was to be worn. A review of the facility's policy titled COVID-19-Resident (effective 05/15/23) revealed: Policy: The Center will follow current guidance for managing COVID-19 . Procedure: 4. Managing a resident with a COVID-19 infection. (a) Place the resident in a single-person room with the door closed, if safe, with a dedicated bathroom. If single person rooms are limited or if numerous residents are simultaneously identified as having COVID-19 symptoms, residents should remain in current location . , (c) Initiate TBP (transition-based precautions), staff will adhere to standard precautions and use the following while caring for a resident, respirator (N95 or higher), gown, gloves and eye protection (goggles or face shield). (d) Limit movement outside room to medically essential needs . 5. Duration of Transmission-Based Precautions: (c) Residents with confirmed COVID-19 Infection.1. At least 10 days have passed since symptoms first appear .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105665	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Aviata at South Daytona		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, interviews, and a review of facility policies and procedures, the facility failed to ensure that the call system was accessible to residents while in their beds for three (Residents #10, #20, and # 31) of a facility census of 59 residents. The findings include: 1. On 8/12/2025 at 11:35 AM, Resident #10 was observed awake in bed. His call light was observed out of his reach under the bed. He was asked how he would get the staff's attention if he needed help. He stated, You push the button, or you holler out. He was asked if he could reach his call light. He was unable to reach it. (Photographic evidence obtained) On 08/13/2025 at 9:24 AM, Resident #10's call light was observed out of his reach under the bed. (Photographic evidence obtained) On 8/13/2025 at 9:30 AM, an interview was conducted with Certified Nursing Assistant (CNA) H. She was asked how residents alerted the staff that they needed help when they were in their rooms. She stated, They use the call light. She was asked what she thought was a reasonable amount of time to lapse before a call light was answered. She stated, I usually answer it as soon as I see it. She was asked what the appropriate placement of a call light was. She stated, Within reach (of the resident). On 08/13/2025 at 9:38 AM, an interview was conducted with Licensed Practical Nurse (LPN) O, who was administering medications in Resident #10's room at the time. She was asked how she determined whether or not residents needed assistance when they were in their rooms. She stated, When I go into the room, I always ask them if they need anything while I'm giving medications. She was asked how the residents summoned help from staff when they were in their rooms. She stated, They use their call bell. She was asked to observe Resident #10 to determine whether his call light was in reach. She confirmed that the call light devices for Resident #10 and his roommate, Resident # 20, were not in reach; they were under the beds. She attempted to place the call lights within reach of the residents but was unable to do so. She stated, I don't know why the call lights are stuck under the beds, but I'll get someone to straighten it out. On 08/13/2025 at 1:05 PM a record review revealed that Resident #10 was admitted to the facility on [DATE]. A review of Resident #10's admission MDS (minimum data set) assessment, dated 7/22/2025, revealed that the resident had a BIMS (brief interview for mental status) score of 12 out of 15 possible points, indicating moderate cognitive impairment. He required partial/moderate assistance with toileting and required supervision/touching assistance with bed mobility and transfers. The MDS indicated the resident was frequently incontinent of urine and always incontinent of bowel. A review of Resident #10's Care Plan revealed the following focus areas: Resident is at risk for falls r/t balance problems, incontinence, poor communication/comprehension, psychoactive drug use. Goal: Minimize risk of minor injury through the review date (initiated 06/11/2025, revised 08/11/2025). Intervention: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. 2. On 08/13/2025 at 9:40 AM an interview was conducted with Resident #20, who was admitted to the facility on [DATE] with a BIMS (brief interview for mental status) score of 15/15, indicating intact cognition. He was Resident #10's roommate. His call light was observed under his bed. He was asked how long his call light had been out of reach, and he replied that he didn't know exactly how long it had been. He stated, It's down there behind the bed somewhere. 3. On 08/11/2025 at 5:00 PM, Resident #31 was observed in bed asleep. The call light was not within her reach. It was located underneath bed A. (Photographic evidence obtained) On 08/13/2025 at 8:50 AM, Resident #31's call light was observed to be out of the resident's reach. (Photographic evidence obtained) An interview was conducted with the resident at this time. She was asked how she was able to let the staff know if she needed help when she was in her room. She stated, I let them know but I do most everything for myself. She was asked if she could reach her call light. She looked for the call light device on the bed where she was sitting and could not locate it. On 08/13/2025 at 3:15 PM, an interview was conducted with the Interim Director of Nursing (DON). She was asked what the facility provided to the residents to use to alert staff that they (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105665	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Aviata at South Daytona		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed assistance in their rooms. She stated, The call bell. She was asked how often call light placement was monitored. She replied, Whenever any staff go into the rooms. She was asked whose responsibility it was to ensure call lights were within the residents' reach. She stated, It's everybody's responsibility. She was asked what her expectation was for the nursing staff regarding call light placement. She replied, The staff need to ensure that call lights are within reach so residents can get the help they need, and I also expect that they respond to the lights; everyone needs to respond to the call lights, not just nursing.		