STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105718	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Central Park	702 S Kings Ave Brandon, FL 33511

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 Level of Harm - Minimal harm or potential for actual harm 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. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record reviews and interviews the facility failed to ensure physician orders were followed by administering medications outside parameters without notifying the physician and the IDT (Interdisciplinary) team for one resident (#1) of three residents reviewed.Findings included: Review of Resident #1's admission record revealed an admission date of 9/15/25 with diagnoses to include but not limited to chronic pain, coronary artery bypass graft, bilateral below the knee amputations (BKA), cardiogenic shock, acute respiratory failure, chronic obstructive pulmonary disease (COPD), diabetes type 2, hypertension and dyspnea. Review of Resident #1's care plan focus: Resident #1 has alteration in acute/chronic pain. Goal: Resident #1 will have minimal interruption in normal activities due to pain. Interventions included to administer analgesia as per orders. Review of Resident #1's order summary report showed Percocet 5-325 mg 1 tablet every 6 hours as needed for moderate pain 4-7 [pain level] ordered on 9/16/25 and discontinued on 9/22/25. Review of Resident #1's medication administration report (MAR) schedule for September 2025 showed:-On 9/16/25 at 9:00 p.m. Percocet 5-325 one tablet was administered for a pain level of 10.-On 9/22/25 at 6:16 a.m. Percocet 5-325 one tablet was administered for a pain level of 8.-On 9/22/25 at 1:14 p. m. Percocet 5-325 one tablet was administered for a pain level of 8. Resident #1's progress notes did not show follow-up documentation to indicate the medical team was notified when ordered parameters for administering medications were not followed. On 11/5/2025 at 9:52 a.m. during an interview, Staff C, Registered Nurse (RN) said she notified the doctor if orders are not followed. On 11/5/25 at 1:50 p.m. during an interview and review of Resident #1's medical record with Staff A, Licensed Practical Nurse (LPN), Unit Manager (UM), Staff A said on 9/16/25 at 9:00 p.m. Resident #1 received Percocet for pain level of 10 and it does not appear the doctor was notified. During an interview with the Director of Nursing (DON) on 11/5/25 at 3:30 p.m., the DON said when medications are given outside of the ordered parameters, nurses are expected to notify the doctor. Review of the facility's policy and procedure titled Pain Management Guideline revised 8/28/2017 revealed: Policy: The center strives to improve patient/resident comfort and minimize pain in order to help a resident attain or maintain his or her highest practicable level of well-being. Purpose: To ensure residents receive the treatment and care in accordance with professionals standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Process: Identification: Evaluate patient/residents upon admission/re-admission, quarterly, with a change in condition or with a new onset of pain. Pain Evaluation: Identify if a resident is experiencing pain using either the resident's self-report of pain (utilizing a 0-10 scale) or for those patient/residents who cannot self-report, use the non-verbal clinical indicators. The Pain Flow Record or electronic equivalent to be maintained in the Medication Administration Record (MAR). Treatment: Develop patient centered interventions (pharmacologic and nonpharmacologic) to manage pain. Document the interventions on the care plan. Monitoring: Monitor and document the patient/resident's response to the interventions. Evaluate the effectiveness of the interventions and progress towards goals. Discuss new interventions and goals with the resident and/or family/resident representative. Update the care plan as indicated. Review of the facility's policy and procedure titled Plans of Care revised 9/25/2017 revealed: Policy: An individualized 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 regulatory requirements . Note: The resident's plan of care encompasses many documents that are part of the resident's clinical record including, but not limited to, structured care plan documents, MARS, TARS, physician orders, flow records, and/or legal documents that would drive the plan of care for the individual resident. Review of the facility's policy and procedure titled Medication Oral Administration revised 8/15/2019 revealed: .Review physician's orders .Review the MAR or EMAR should there be any uncertainties verify the MAR or EMAR with the Physician's Order Sheet (POS) and seek clarification as indicated.