STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 observation, interview, and record review, the facility failed to maintain the only Americans with Disabilities Act (ADA)-accessible public entrance in operable condition. As a result, residents using wheelchairs were unable to independently enter the facility and were required to wait outside until staff or others opened the door for them for 3 of 3 resident reviewed for preferences of a total sample of 10 residents, (#5, #6, and #7).Findings: On 6/30/26 at 9:16 AM, as the surveyor was about to enter the facility, the handicapped-accessible button located to the right of the outside entrance door was pressed; however, it did not open the doors. The second set of interior doors was opened by the receptionist. On 6/30/26 at 9:18 AM, when asked about the handicapped-accessible button outside not working, the receptionist stated it did not work and it had not worked for a while. She explained she could open the inside doors with a control button at her desk; however, to open the outside doors, she had to manually press a button located just inside the entrance, and only the right door would open. On 6/30/26 at 9:42 AM, resident #6 was sitting in his wheelchair in his room and stated he obtained a daily leave of absence (LOA) pass because he liked to sit outside. He pointed to an outside area that could be seen through the window and back door. He showed the LOA pass he obtained that day and stated he would soon be leaving. He said he looked forward to spending time outside each day because he previously worked at a local home improvement store and received visits from former coworkers or friends while outside. He shared when he reached the main entrance, the receptionist opened the interior entrance doors using the button at her desk, and he pressed the other button to exit. He stated once he was ready to return inside, he had to call the facility or wait for someone to enter the building and assist him by opening the door. He indicated the handicapped-accessible button outside had not worked for at least 5 months and said he always mentioned it during the town hall meetings he attended regularly. He said he was always told they are waiting for corporate to approve it. On 6/30/26 at 9:52 AM, resident #5 was sitting in his wheelchair outside the facility to the right of the main entrance, within view of the entrance doors. He stated he had lived in the facility approximately 8 years. He confirmed the handicapped-accessible button at front entrance was not working and said it was one of the things he had gotten used to. He indicated electricians had worked on the door but could not get it working properly. He said the receptionist had to get up and push the buttons throughout the day. He stated the issue had existed for more than 6 months and he had never seen anything like it. He said he was astonished the problem had not been fixed despite experts having worked on it and commented it was unusual they could not determine the cause. On 6/30/26 at 11:38 AM, resident #7, who was sitting in a wheelchair by the door of his room, stated the handicapped-accessible button at the main entrance had not worked for months. He indicated the facility administration was aware of the problem and nothing had been done to correct it. He shared he once observed a resident waiting until someone opened the door to assist him back inside. He added there was not even a buzzer to alert someone inside to open the door. He stated his sister held the door open for him whenever they went outside. On 6/30/26 at 4:33 PM, resident #1's family member stated the entrance door needed repair and had been broken for over a year. She explained (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the door had to be opened manually. She stated this was very difficult for someone using a wheelchair. She shared when she arrived to visit her family member, residents were sometimes waiting outside and had said, Oh good, please let me in. She stated residents who enjoyed going outside through the main entrance required assistance to enter and exit the building. She explained she frequently brought supplies for her family member, including water, juice, and clean laundry in a cart, and it was difficult to enter because the handicapped-accessible button was not functioning and she had to manually open the door. She stated she did not always receive assistance from the front desk staff. She further stated she had personally helped residents re-enter the building because no one had been available to assist them. She concluded, This would all be solved if they would just fix the handicap button. The facility is cutting corners at the expense of the residents. On 6/30/26 at 10:07 AM, the Activities Coordinator stated the handicapped-accessible button at the main entrance had not been operational for over a year but should be repaired. She explained when exiting, the button worked but only opened the right door. She indicated the inside doors could be opened by the receptionist using a control button. She mentioned it made it difficult when bringing supplies into the building. She stated she participated in resident council meetings and only one resident brought up the issue because he went outside often. She mentioned both the Director of Maintenance and the Administrator (NHA) were aware of the problem. She added the facility had someone attempt to repair it, but it continued not to work, and the repair was very expensive. On 6/30/26 at 1:12 PM, the Director of Maintenance stated he was responsible for the general building, including repairs and maintenance. When asked about the issue with the main entrance door and handicapped-accessible button, he produced a quotation dated 4/20/26 to correct the problem. He stated he had forwarded the quotation by email to the [NAME] President (VP) of Plant Operations. He mentioned he could not locate another vendor to provide an additional quotation. He explained the door had been repaired in April; however, the system was so old it required a complete upgrade. He stated he had done everything within his control, but the matter was beyond his authority. He indicated the NHA was aware of the situation. He explained the door worked only from the inside and that pressing the interior button caused only one door to open outward. He stated it was the facility's ADA-accessible entrance and acknowledged it should be operational. He confirmed family members and a resident had raised concerns about the door during resident council meetings. He stated he informed them the facility was aware of the issue and was working on it. Later, at 1:12 PM, the Director of Maintenance indicated he reviewed his maintenance logs from September 2025 through June 2026 at the surveyor's request but found no documentation of the issue and could not determine how long it had existed. On 6/30/26 at 2:16 PM, the NHA stated she was responsible for ensuring the day-to-day operations of the facility ran smoothly and the residents were safe and received appropriate care. She stated she first became aware of the main entrance door issue at the beginning of the year when the Director of Maintenance informed her of the problem. She explained the Director of Maintenance had contacted several companies, obtained multiple quotations, and was awaiting approval from the VP of Plant Operations. She stated the matter was something a little higher than her and would need to be approved by the VP of Plant Operations. When asked how long the approval process took, she stated it depended on different factors. She confirmed this was the facility's only ADA-accessible public entrance. She acknowledged it was important for the issue to be corrected so residents and visitors with disabilities had unrestricted access into and out of the facility. When asked about the facility's policy regarding the physical environment, she stated the facility did not have one. Review of the email communication between the prospective vendor and the Director of Maintenance dated 4/20/26 included a description of the work and a price quotation for the door access system. The email message was forwarded to the Regional Plants Operations (RPO) on 4/21/26. Review of the email message dated 4/22/26 between the vendor and Director of Maintenance read, If you want we can look at just fixing what you have, your set up right now is with the RF (radio frequency) wireless push to open units that connect to the mechanical door opener above the doors, the one set of doors that (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	only one door opens is most likely a connection issue or malfunction in the door opener above the door. The push to open units are like a garage door opener so most can just have a new push button and sync it to the existing RF receiver. The Director of Maintenance forwarded the response message to the RPO on 4/27/26. Review of the email dated 5/14/26 from the RPO to the Director of Maintenance, with copy to the VP of Plant Operations, included a message addressed to the VP of Plant Operations which read, . attached is the door opener quote from a local vendor for (name of the facility). (Company name) stated they do not provide this service, and the local company quoted a system that requires a cloud system to operate with a subscription. They stated they could attempt to repair the system that has been worked on by multiple companies, but it is unlikely they can get system to work with its age and availability of parts. Review of the response from VP of Plant Operations dated 5/15/26 read, Why can't the push buttons be replaced with the same RF set up. The controllers are only $200 on Amazon. Review of the vendor's quotation document dated 4/20/26 indicated the total cost to correct the main entrance door issue would be $6,177.92. The description read, Customer has stand alone 2 door access with RF push to release needing new set up. The quotation stated the price was valid for 30 days and did not include any applicable state tax. Review of the Director of Maintenance/Maintenance Supervisor job description, signed by the Director of Maintenance and the NHA on 6/02/25, revealed he was responsible for planning, organizing, developing, and directing the overall operation of the Maintenance Department in accordance with federal, state and local standards, guidelines, and regulations governing the facility, ensuring the facility was maintained in a safe and comfortable manner. The job description further indicated he was responsible for the upkeep pf the facility, including the building, building systems, and grounds, and played a key role in the facility's safety program. Review of the Facility assessment dated [DATE] revealed an assessment of the physical environment, equipment, services, and other physical plant considerations necessary to care for residents. The assessment included a table listing categories, resources, and processes to ensure adequate supply, appropriate maintenance, and replacement. Under Other physical plant needs, it included, sliding doors, ADA-compliant entry/exit ways, and ingress/egress doors were evaluated daily by the Director of Maintenance for proper functioning.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a comprehensive significant change in status assessment for 1 of 1 resident review for Activities of Daily Living (ADLs) in a total sample of 10 residents, (#1).Findings: Review of the medical record revealed resident #1 was readmitted to the facility on [DATE] with diagnoses including unstageable sacral pressure injury, functional quadriplegia, type 2 diabetes, and chronic obstructive pulmonary disease. Review of resident #1's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/28/26 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. The MDS assessment showed resident #1 required substantial/maximal assistance from staff for eating, oral hygiene, upper body dressing and personal hygiene. Resident #1 was dependent for toileting hygiene, showering/bathing, lower body dressing, and putting on and taking off footwear. The MDS assessment also showed resident #1 required substantial/maximal assistance with bed mobility, including rolling left and right, sit-to-lying, lying-to-sitting on the side of the bed, sit-to-stand, chair/bed-to-chair transfers, and toilet transfers. Review of resident #1's quarterly MDS assessment with an ARD of 5/31/26 revealed a BIMS score of 13 out of 15, indicating intact cognition. The MDS assessment showed resident #1 was now dependent on staff for all ADLs, including eating, oral hygiene, upper body dressing, personal hygiene, toileting hygiene, showering/bathing, lower body dressing, and putting on and taking off footwear. The MDS assessment also showed resident #1 was now dependent for rolling left and right in bed and chair/bed-to-chair transfers. Sit-to-lying, lying-to-sitting on the side of the bed, sit-to-stand, and toilet transfers were documented as not attempted due to the resident's medical condition or safety concerns. Review resident #1's care plan, initiated on 5/12/26, revealed the resident had a decrease in ADL function related to physical limitations and decreased motivation. On 6/30/26 at 11:12 AM, resident #1 stated he needed assistance with everything because he could no longer move his hands or arms. He stated he required assistance with meals because he was unable to manage a spoon independently. He indicated when he was admitted , he was able to do certain things independently; however, he had experienced a decline in his ability to perform those activities. On 6/30/26 at 12:35 PM, Certified Nursing Assistant A stated resident #1 was totally dependent on staff for all ADLs. She indicated he could not move his arms or legs and required staff assistance with meals, drinks, and using the telephone. On 6/30/26 at approximately 5:35 PM, the Director of Nursing and the Regional Nurse Consultant reviewed resident #1's medical records and acknowledged a significant change in status assessment had not been completed despite the decline in ADLs identified in the quarterly MDS assessment with an ARD of 5/31/26. On 6/30/26 at 5:56 PM, resident #1's MDS assessments and ADLs were reviewed with the MDS Lead and MDS Coordinator. The MDS Lead confirmed the findings documented on each MDS assessment and acknowledged resident #1 had declined in more than two ADLs from the admission assessment to the quarterly assessment. She confirmed resident #1 met the criteria for a significant change in status assessment; however, one had not been completed and did not provide an explanation for why it had not been performed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the resident's care plan for toileting for 1 of 1 resident reviewed for Activities for Daily Living (ADLs) in a total sample of 10 residents, (#1).Findings: Review of the medical record revealed resident #1 was readmitted to the facility on [DATE] with diagnoses including unstageable sacral pressure injury, functional quadriplegia, type 2 diabetes, and chronic obstructive pulmonary disease. Review of resident #1's quarterly Minimum Data Set assessment with an Assessment Reference Date of 5/31/26 revealed a Brief Interview for Mental Status score of 13 out of 15, indicating intact cognition. The MDS assessment showed resident #1 was dependent on staff for all ADLs, including toileting hygiene. The MDS assessment also showed resident #1 was dependent for rolling left and right in bed and chair/bed-to-chair transfers. Sit-to-lying, lying-to-sitting on the side of the bed, sit-to-stand, and toilet transfers were documented as not attempted due to the resident's medical condition or safety concerns. Review of resident #1's care plan, initiated on 5/12/26, revealed the resident had a decrease in ADLs related to physical limitations and decreased motivation. Interventions included developing and implementing a personalized care routine that promoted independence while ensuring safety. Review of another care plan, dated 3/25/26, revealed an alteration in unusual functional performance in self-care related to a recent hospitalization and impaired mobility. Interventions revised on 5/28/26 included toileting and bed mobility, including rolling from side to side and side to back, and indicated resident #1 was dependent and required the assistance of two staff members for toileting and bed mobility. On 6/30/26 at 11:12 AM, resident #1 stated he needed assistance with everything because he could not move his hands or arms. He stated he required assistance with meals because he was unable to manage a spoon independently. Later, at 4:03 PM, resident #1 stated the majority of time, the Certified Nursing Assistant (CNA) assigned to him that day came with another staff member to change him; however, if she could not find someone to assist, she changed him by herself. He further stated she was very efficient but explained he was dead weight. He stated he could no longer move his hands and had gradually declined since his admission. He indicated only two CNAs who were very tall were able to provide his care independently. On 6/30/26 at 12:35 PM, CNA A stated resident #1 was totally dependent on staff for all ADLs . She indicated he could not move his arms or legs and required assistance with meals, drinks, and using the telephone. She stated she overheard another CNA say she could no longer change resident #1 by herself and was waiting for someone to assist her; however, the larger CNAs were able to provide his care independently. She confirmed resident #1 could not roll to his left or right side without assistance and said he could not do anything. She stated when resident #1 was admitted to her unit, staff were told two staff could assist him, but it was not mandatory. She confirmed staff could ask another employee for assistance if needed; however, she reiterated it was not required and stated she provided toileting care by herself. She stated she reviewed residents' care plans when she was unfamiliar with a resident but also learned residents' care needs through verbal communication with nurses or other CNAs. On 6/30/26 at 6:00 PM, the Director of Rehabilitation stated Occupational Therapy (OT) discharged resident #1 on 6/25/26 after determining he had plateaued . She confirmed the OT Discharge Summary documented resident #1 was dependent for all ADLs and required the assistance of two staff members for all care except eating, oral hygiene, putting on and taking off footwear, and personal hygiene. On 6/30/26 at 6:08 PM, the Director of Nursing reviewed resident #1's medical record and confirmed the resident required the assistance of two staff members during toileting. Review of the facility's policy titled Plans of Care, revised 9/25/17, revealed an individualized person-centered plan of care would be developed for each resident based on the comprehensive assessment to address the resident's identified medical, nursing, mental, and psychosocial needs.