

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105895	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Aviata at Seminole		STREET ADDRESS, CITY, STATE, ZIP CODE 9393 Park Blvd Seminole, FL 33777	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to obtain a blood pressure prior to the administration of an antihypertensive with physician ordered parameters for one resident (#16) of two residents sampled during medication administration. Findings included: On 11/17/25 at 9:17 a.m. Staff A, Registered Nurse (RN) was observed standing at a medication cart on the 200-hall. Staff A reported finishing up (med administration) with one resident but did have others. The process of medication administration was explained to Staff A. Staff A dispensed the following medications for Resident #16:-Senna Plus 8.6-50 milligram (mg) over the counter (otc) tablet-Amlodipine 5 mg tablet-Aspirin Enteric coated otc 81 mg tablet-Vitamin D 25 microgram (mcg) otc tablet-Pancrelipase Creon Delayed Release (DR) 24000 unit tablet- Dicyclomine 20 mg tablet-Duloxetine 30 mg caplet-Oxycodone 10 mg tabletStaff A dropped the Oxycodone tablet onto the top of medication cart, picking it up with bare hands, and placed it into the medication cup. Staff A signed out the controlled substance in the narcotic book and opened the resident's closed book. Staff A was asked to stop and return to the cart. Staff A stated placing a medication which had dropped onto the cart into the med cup wasn't something normally done, would waste it. Staff A, confirmed the other tablets in cup had been contaminated and the medication would have to be dispensed again. Staff A re-dispensed the medications, entered Resident #16's room, asking if the resident wanted Lactulose or Combivent (which was refused). Staff A returned to the cart.Review of Resident #16's admission Record showed the resident was originally admitted on [DATE] and readmitted on [DATE]. The record included diagnoses not limited to unspecified chronic obstructive pulmonary disease, atherosclerotic heart disease of native coronary artery without angina pectoris, other sequelae following unspecified cerebrovascular disease, and essential (primary) hypertension. Review of Resident #16's November Medication Administration Record (MAR) revealed:-Norvasc 5 mg (Amlodipine) 5 mg - Give 5 mg by mouth once a day for hypertension (HTN). Hold if systolic blood pressure (SBP) is less than 120 or diastolic blood pressure (DBP) is less than 60. The order started on 2/4/25. The MAR documentation showed the medication was to be administered in the morning (MORN) and did not include an area for staff to document a corresponding blood pressure.-Monitor vital signs every day shift. The MAR showed staff documented vital signs were monitored daily without noting the blood pressure, pulse, temperature, and respiration rate. The monitoring was scheduled for 12 Da.-Weekly vital signs every Monday (Mon) (and) Thursday (Thu) for hypertension (HTN). The order started on 8/28/25. The documentation showed nursing staff were documenting blood pressures on Mondays and Thursday with the exception of 11/10/25 which showed not applicable NA for both blood pressure and pulse. The MAR did not require staff to document temperature or respiration rates as part of the vital signs readings. Review of Resident #16's Medication Admin Audit Report for 11/17/25, showed Staff A had administered a dose of Amlodipine (Norvasc) at 9:19 am. and documented the administration at 9:23 a.m. The report revealed the staff member documented on 11/17/25 at 7:13 a.m. monitoring of vital signs had been completed and showed the resident's weekly vital signs were scheduled at 11:45 a.m. (after the Amlodipine was to be administered) and the staff member had administered the vital signs at 2:07 p.m. and documented them at 2:13 p.m. (approximately 5 hours after the administration of (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Amlodipine). Review of Resident #16's progress notes on 11/17/25 at 1:34 p.m. did not show documentation of the resident's blood pressure at the time of Amlodipine administration on 11/17/25. An interview was conducted with, Staff A on 11/17/25 at 1:39 p.m. Staff A stated Resident #16's blood pressure had been 127/68 or something like that. Staff A reported Resident #16 was currently having chest pain and the blood pressure was lower than that something like 100/48. Staff A reported being able to look up the blood pressure (from this morning), (Staff A was informed to assist the resident by this writer), Staff A went to the computer behind the nursing station and showed the resident's dashboard was active revealing a blood pressure of 124/68 from 11/13/25. Staff A said (pronoun) didn't know why the mornings blood pressure wasn't showing up. Review of Resident #16's progress notes on 11/18/25, showed Staff A had documented on 11/17/25 at 1:58 p.m. the resident had complained of chest pain which radiated down left arm, blood pressure was taken and showed to be 100/47, the nurse practitioner was notified and ordered one dose of nitro(glycerin), the resident refused the dose, and vital signs at the time were 120/55. Review of Resident #16's assessments on, 11/18/25 at 9:26 a.m. showed a weekly skin review had been completed on 11/17 and the previous assessment was a Brief Interview for Mental Status (BIMS) evaluation completed on 11/11/25. The evaluation showed a score of 12 indicating moderate impairment. The assessments did not show staff were completing daily assessments for the resident which could have included vital signs. Review of Resident #16's blood pressure summary on 11/17/25 at approximately 1:00 p.m. showed the latest blood pressure reading was on 11/13/25 at 11:53 a.m. of 124/68. The review showed readings on 11/9, 11/7, 11/6 at 11:32 am. of 150/84 and one at 5:15 p.m. of 150/84, 11/3, 10/30, 10/27, 10/23, 10/20, 10/16, 10/14, 10/13, and 10/9/25. Review of Resident #16's November MAR, Blood pressure summary, assessments and progress notes showed staff had administered amlodipine without obtaining and documenting the resident's blood pressure at the time of administration or held the medication related to the physician ordered parameters:-11/14 to 11/17/25 no blood pressure was documented and Amlodipine was administered.-11/10 to 11/12/25 no blood pressure was documented and Amlodipine was administered. On 11/10 the MAR showed nursing staff had documented not applicable NA for weekly vital signs.-11/9/25 a blood pressure of 111/69 had been recorded at 7:05 a.m. by the night shift nurse and Amlodipine was administered by the day shift nurse.-11/8/25 no blood pressure was documented and Amlodipine was administered.-11/7/25 a blood pressure of 112/66 was documented at 11:13 a.m. and showed Amlodipine had been administered.-11/4-11/5/25 no blood pressure was documented and Amlodipine had been administered.-11/1-11/2/25 no blood pressure was documented and Amlodipine had been administeredThe review showed out of 17 opportunities Amlodipine had been administered 15 times without documentation of blood pressure at the time of administration, twice Amlodipine had been administered when blood pressure was outside of parameters and should have been held. Review of Resident #16's follow up Cardiology physician visit on 11/3/25 at 4:10 p.m. showed the resident had a past medical history of paroxysmal atrial fibrillation, coronary artery disease (CAD), hypertension, and hyperlipidemia. The medical necessity for cardiology was described as Follow up for cardiac med reconcile, titrating cardiac meds, lab follow up, following volume status, adjusting diuretics as needed, monitoring hemodynamic/symptoms during and post physical therapy, and increased risk for cardiac re-admission. The assessment for essential hypertension (HTN) showed the diagnosis was controlled on Norvasc 5 mg daily, asymptomatic, SBP less than 130, avoid hypotension, and monitor vital signs. The note instructed to maintain current plan of care, including regular assessment of vital signs, labs, and overall status. Review of Resident #16's care plan showed a focus revealing the resident had altered cardiovascular status related to (r/t) hypertension, CAD, (and) history of tachycardia. The associated interventions included instructions for staff to administer medications as ordered and monitor vital signs (and) notify the MD of significant abnormalities. An additional focus revealed the resident had hypertension and took BP medications. The interventions instructed staff to Give anti-hypertensive medications as ordered. Monitor of side effects such as orthostatic hypotension (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and increased heart rate (tachycardia), and effectiveness. An interview was conducted with Resident #16 on 11/18/25 at 9:40 a.m. The resident stated staff do not take blood pressure on a regular basis, not daily maybe once or twice a week. The resident stated they took blood pressure yesterday (day of medication administration) after telling them (pronoun) didn't feel good. An interview was conducted with Staff B, Licensed Practical Nurse (LPN) who identified self as Resident #16's nurse, on 11/18/25 at 9:43 a.m. Staff B reported working the hall every couple of weeks but knew everyone on the hall. Staff B stated in regard to how often (pronoun) took Resident #16's blood pressure rarely. During an interview on 11/18/25 at 11:15 a.m. the Assistant Director of Nursing (ADON) stated vital signs are taken on admission, any change in condition, if skilled once a shift, if any medication (require), if blood pressure meds are taken and have parameters for blood pressure, if administering nitro take blood pressure, and obtain blood glucose before giving insulin. The ADON stated staff should be documenting blood pressure if there is a parameter, if there is a parameter the medication should have a pop-up box to put in the blood pressure, and believed the blood pressure documented in the pop-up box showed up on the MAR. Review of Resident #16's MAR was conducted and the ADON confirmed blood pressures were not documented with the administration of Norvasc. The ADON reviewed the order to monitor vital signs daily and stated if they aren't documented they weren't done. The ADON reviewed blood pressure summary and confirmed blood pressures were not done prior the administration of the resident's Amlodipine and stated the nurse had backfilled the blood pressure on 11/17 (after photo had been obtained). The ADON stated blood pressures should be taken immediately prior to the administration of the medication. Review of the policy - Administering Medications, revised April 2019, revealed Medications are administered in a safe and timely manner, and as prescribed. The policy included but was not limited to the following:-2. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions.-4. Medications are administered in accordance with prescriber orders, including and required time frame.-10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.-11. The following information is checked/verified for each resident prior to administering medications:o a. Allergies to medications; [NAME] b. Vital signs, if necessary.		