STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105951	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Oakfield	1465 Oakfield Dr Brandon, FL 33511

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to document and plan the discharge process, for one of three residents sampled (Resident #1).Findings Included:During an interview on 01/05/26 at 12:47 PM, Resident #1's representative stated the resident was discharged home without supplies and the home health care company did not show up. During an interview on 01/05/26 at 01:22 PM, with Staff B, Social Services Worker (SSW), and the Social Services Director, SSD. Staff B, SSW stated the home health care provider had not been confirmed for Resident #1, prior to discharge on [DATE]. Staff B, stated no supplies were provided to Resident #1 at discharge. Staff B, stated Resident #1 was not reached out to post discharge from the facility. Staff B, stated being made aware the home health care provider had declined to admit Resident #1. Resident #1 had to ascertain a different home health care provider. Review of Resident #1's admission Record revealed the resident was admitted to the facility on [DATE] and discharged [DATE] with the following diagnosis: sepsis, osteomyelitis of the femur, chronic obstructive pulmonary disease, muscle weakness, malignant neoplasm of rectum, colostomy, chronic kidney disease and female genital tract fistula. Review of Resident #1's care plan did not reveal a plan for discharge. Review of Resident #1's orders dated 12/15/25 revealed wound care treatment orders for daily dressing changes to the coccyx. Review of Resident #1's progress notes revealed: a nursing progress note dated 12/19/25 at 2:26 PM, revealed Resident #1 went home via a stretcher with one driver.Review of Resident #1's social service discharge note dated 12/19/25 at 3:31 PM, revealed Resident #1 was to receive home health.Review of Resident #1's physician progress note dated 12/22/25 at 9:27 AM, revealed Resident #1 was ready for discharge. The note revealed a social worker arranged home health care.Review of Resident #1's progress notes lacked documentation of discharge planning with Resident #1 and/or Resident #1's representative. Review of Resident #1's social service progress note dated 12/23/25 at 1:34 PM, revealed a post discharge note which showed social services spoke with Resident #1's family member and was informed home health had not shown up. Social services called the initial home health company and confirmed the company had not agreed to care for Resident #1.During an interview on 01/05/26 at 2:16 PM, the Assistant Director of Nursing (ADON), Director of Nursing (DON), and the Nursing Home Administrator (NHA), stated Resident #1 had a stage three pressure injury on the coccyx. The DON stated Resident #1 had physician orders for daily wound care. The DON stated there was no information documented for the nurse's role in Resident #1's discharge. The DON confirmed there should be documentation regarding education, and any supplies given to the resident at time of discharge. Review of the facility policy titled Discharge Planning, dated 11/30/14 revealed: Policy: To evaluate the resident's health status and formulate the best plan of discharge for each resident. Discharge Planning begins the day of admission. The process involves the resident and family, Care Management/Social Services and other members of the clinical team. 1. An initial evaluation of resident is completed upon admission. A (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge goal and length of stay will be established upon admission and reviewed/revised at plan of care conferences. The goal is based upon clinical findings, availability of community and family resources and resident/family goals. 2. Discharge planning record will be completed within seven days after admission. Discharge planning is adjusted as appropriate. 4. At the time of discharge, a discharge summary and home-going instructions are provided to the resident or the resident's caregiver which will include the following: current diagnosis, rehabilitation potential, summary of prior treatment, physician orders for immediate care, pertinent social information, community referrals as needed (e.g., home health, mental health, adult daycare, etc.) 5. Residents discharged to home will be made aware of, understand and agree with the proposed discharge plan, discharge date and other home care needs. 6. Within twenty-four (24) to forty-eight (48) hours (or next day) after discharge to home, another nursing facility or to another type of residential facility such as a board-and-care home, a follow-up phone call, or if necessary, home visit will be made to ascertain that community services/referrals are indeed being provided according to the discharge plan. 7. Documentation of the after discharge contact will be made on the social service progress note and labeled Post-Discharge Note. 8. Should pre-scheduled services not be provided or arranged, the social worker will make every attempt to coordinate service and follow-up again.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure treatment and care in accordance with professional standards of practice by failing to implement post fall evaluations, for one (Resident #1) of three residents reviewed for falls. Findings included: Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include: sepsis, unspecified organism, muscle weakness, and other abnormalities of gait and mobility. Review of the Minimum Data Set revealed Resident #1had a Brief Interview Mental Status of 15, which indicated cognition was intact. Review of the functional abilities and goals section revealed the resident used a walker or wheelchair, required substantial or maximal assistance for showering, bathing, toileting hygiene, personal hygiene, and upper body dressing, and required assistance from two or more helpers to roll left and right, go from sitting to lying, lying to sitting on side of bed, and from sitting to standing. Review of Resident #1's fall assessment dated [DATE], revealed Resident #1 had not experienced a fall within six months prior to admission and Resident #1 had impaired mobility and cognitively intact. The assessment revealed Resident #1 was a low fall risk. Review of Resident #1's progress note dated 12/18/2025 at 01:05 PM, revealed: upon doing room checks nurse observed resident on the floor beside her bed. nurse asked resident what happened. resident stated she tried to push herself back in the and slipped into the floor. resident assessed head to toe red mark on forehead, skin tear left elbow. CNA and nurse used [mechanical] lift used to place resident back in bed. Review of Resident #1's medical chart did not reveal a neurological check post incident, or other fall related assessments. During an interview on 01/05/2026 at 02:16 PM, the Assistant Director of Nursing (ADON), Director of Nursing (DON), and the Nursing Home Administrator (NHA) stated Resident #1 had an unwitnessed fall. The DON read a progress note from Resident #1's medical record, which revealed the resident had been observed on the floor on 12/18/2025, related to an unwitnessed fall. The ADON stated Resident #1 had an unwitnessed fall on 12/17/2025. The ADON stated the facility did not ask Resident 1 if the red mark on Resident #1's forehead was due to a head injury. The ADON stated not knowing what the red mark on Resident #1's forehead was. The ADON stated the facility took the residents' words on it. The ADON stated Resident #1 did not incur an injury as a result of the fall. The DON read a progress note dated 12/18/2025 at 01:05 AM, which revealed Resident #1 had a red mark on the forehead and a skin tear to the left elbow. The DON stated unwitnessed falls require monitoring, neuro checks, complete skin assessments, treatment for possible skin care, frequent monitoring, and a range of motion assessments. The DON stated the required steps for post fall care had not been completed for Resident #1, after the fall. The DON stated the ADON had reviewed the resident's files and was unable to find neuro checks for Resident #1. Review of a policy titled Fall Management, revised 07/29/2019, revealed: Policies and ProceduresResidents are evaluated for fall risk. Patient centered interventions are initiated, based on resident risk. A fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as the result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.Purpose:Is to identify residents at risk for falls and establish/modify interventions to decrease the risk of a future fall (s) and minimize the potential for a resulting injury.C. Post Fall Strategies:1. Resident will be evaluated and post fall care provided2. Initiate Neurological checks as per policy or directed by physician order3. Notify the Physician and resident representative4. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Re-evaluate fall risk utilizing the Post Fall Evaluation5. Update Care plan and Nurse Aide Kardex with intervention(s)6. Initiate post fall documentation every shift for 72 hours7. Interdisciplinary Team to review fall documentation and complete root cause analysis8. Update plan of care with new interventions as appropriate9. Review resident weekly times 4.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure urostomy and nephrostomy tubes care was provided and was consistent with professional standards of practice for one (Resident #1) out of three residents reviewed.Findings included: Review of Resident #1's medical certification for Medicaid long-term care services and patient transfer form (3008), dated 11/26/25 Section P-Patient Health Status showed the following urostomy, bilateral [nephrostomy] tubes and colostomy. During an interview on 1/5/26 at 12:33 pm. the Director of Nursing (DON) said at the time of admission to the facility batch orders (standing orders) are ordered based on the hospital discharge orders. The DON stated at the time of Resident #1's admission the orders should have addressed the care of the urostomy and nephrostomy tubes. When asked about Resident #1 missing orders for the care of the urostomy and nephrostomy tubes, the DON stated, I can't speak to that; I have no information. A review of Resident #'1's admission record revealed admission to the facility on [DATE], with diagnoses including sepsis, acute osteomyelitis, Chronic Obstructive Pulmonary Disease (COPD), chronic kidney disease (CKD), artificial openings of urinary tract, female genital tract fistula, history malignant neoplasm of large intestine, colostomy status and deep vein thrombosis (DVT). A review of admission/readmission data collection revealed Resident #1 was admitted to the facility on [DATE] at 8:00 p.m. Section J, gastrointestinal, showed presence of a colostomy. Section K, genitourinary, does not show the presence of urostomy tube and or nephrostomy tube. A review of Resident #1's Minimum Data Set (MDS), admission assessment dated [DATE] Section H-Bowel and Bladder revealed Resident #1 has nephrostomy tube and ostomy (include urostomy . colostomy). A review of physician orders, as of 12/19/25 revealed the following:An order dated 12/5/25, Procedure: Colostomy appliance change order: change colostomy bag and wafer now. Skin Care: clean peristomal skin with water only; pat dry. Apply skin barrier wipe and ensure full drying before wafer placement.Supplies: Use patient specific colostomy supplies per formulary.Monitoring: Notify provider for peristomal skin breakdown, persistent leakage, bleeding, or concern for infection. A review of Resident #1's care plan, dated 12/10/25, revealed a focus area as follows: [Resident #1] has skin excoriation on the sacrum and coccyx .related to (r/t) . [ileal conduit], ostomy and nephrostomy tubes. A review of Resident 1's Nurse Practitioner (NP) follow-up note, dated 12/12/2025 revealed, physical exam: incontinent of bowel and bladder colostomy, urostomy and nephrostomy tubes [bilaterally] .all appliances intact at today's exam. Continue daily assessment for leakage, obstruction, decreased output, skin breakdown or signs of infection at infection sites. Maintain meticulous stoma and nephrostomy care. Monitor urine color and output; report hematuria (blood in urine), foul odor, or catheter-related pain. High Risk statement: multiple ostomies and nephrectomy tubes significantly increase risk for urinary obstruction, pyelonephritis, skin breakdown, electrolyte imbalance, and sepsis. Report any change . The plan of care was discussed and collaborated with [nursing] staff. Clinical documentation was available to Unit Manager (UM)/Director of Nursing (DON), as well as physician . A review of Resident #1's physician progress note, dated 12/18/25 revealed the following: the patient has a permanent Colostomy, ileal conduit urostomy, and bilateral nephrostomy tubes. All appliances are intact on today's exam. Daily monitoring will continue for leakage, obstruction, decreased output, skin breakdown, hematuria, foul odor, or insertion site infection. High Risk statement: multiple ostomies and nephrectomy tubes significantly increase risk for urinary obstruction, pyelonephritis, skin breakdown, electrolyte imbalance, sepsis and hospitalization . Clinical documentation was available to Unit Manager (UM)/Director of Nursing (DON), as well as physician . During an interview on 1/5/26 at 12:33 p.m. Staff A, Licensed Practical Nurse (LPN) (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said when caring for a resident with ostomies the nurses follow physician orders. During a follow-up interview on 1/5/26 at 4:33 p.m. the DON said nurses are expected to reconcile hospital discharge orders with the physician upon admission. All orders must be entered into the electronic medical record system. For residents with a colostomy or nephrostomy, care is provided every shift and as needed. Care orders are reflected in the Treatment Administration Record (TAR). The frequency of changing colostomy bags is resident-specific and depends on stool consistency, physician orders, and PRN needs. The physician's order specifies how often the colostomy bag should be changed. Ostomy care is documented on the TAR. The Minimum Data Set (MDS) nurse is responsible for making sure this information is incorporated into the resident's care plan. Review of facility's policy and procedure titled, Clinical Guideline Skin & Wound Document, effective date 4/1/2017 revealed the following:Overview: To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/ prevention of pressure injury.Process . Develop individualized goals and interventions and document on the care plan and the CNA Kardex . Monitor residents' response to treatment and modify treatment as indicated. Evaluate the effectiveness of interventions, and progress towards goals during the care management meeting and as needed. Review of facility's policy and procedure tiled, Plans of Care, revised 9/25/2017 revealed the following: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.Procedure:-Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment .-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 interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being.-The Individualized Person-Centered plan of care may include but is not limited to the following: Resident's strengths and needs-Services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required by 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.