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	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Oakfield	1465 Oakfield Dr 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure resident accessible water temperatures were maintained at safe and comfortable levels, not to exceed the required temperature of 105 - 115 degrees Fahrenheit (F) in two units (100,300) of three units, affecting three rooms (204, 315 and 113). Findings included: On 4/13/2026 at 9:10 a.m. during an initial tour of resident rooms revealed water flow temperatures too hot to hold the back of the hand under in the resident bathroom sinks in rooms [ROOM NUMBER].On 4/13/2026 at 11:00 a.m. during an interview with the Director of Maintenance (DOM), he stated he had been the DOM at the facility for four months and did not have an audit plan to include water temperature testing at individual resident room sinks. He stated he sets the facility's water heaters at a certain temperature and will read the flow temperature from that specific heater. The DOM stated the water heaters are set at around 110 - 115 degrees. He was not sure how many water heaters there were in the building but confirmed there were at least three for the resident rooms and shower rooms as well as separate water heater booster for the kitchen and laundry room. The DOM was not sure what those water heaters/booster temperature were set at. The DOM confirmed he did not have any documented evidence of testing hot water temperatures in each resident rooms and stated he did not know that was something he needed to do. During the tour and interview, the DOM conducted water temperature tests for several resident rooms that were in question. He used a digital thermal infrared thermometer and revealed he did not need to calibrate it, as it was battery powered. He said he was not sure there were ways to calibrate the device, but clarified it reads correctly, when in use. On 4/13/2026 at 11:09 a.m. the DOM tested the water temperature in resident room [ROOM NUMBER]'s bathroom sink. After he turned on the hot water and let it run for approximately two minutes, he was observed to cup his hand and let the water flow run through it. The DOM then pointed the thermometer at his cupped hand and began the reading. The thermometer read out screen reached 121 degrees F. On 4/13/2026 at 11:11 a.m. the DOM went into resident room [ROOM NUMBER] and tested the hot water. He turned on the hot water and let it flow for approximately two minutes and then cupped his hand to let the water flow in it. The thermometer read out screen read 121 degrees F. On 4/13/2026 at 11:13 a.m. the DOM went into resident room [ROOM NUMBER] and did the same water temperature demonstration and he was not able to hold his hand under the water flow for a short period of time. He pointed the thermometer at the water flow, and the read-out screen read 124 degrees F. On 4/13/2026 at 12:33 p.m. the DOM went into resident room [ROOM NUMBER] and did the same water temperature demonstration. The hot water temperature reached 121 degrees F. On 4/13/2026 at the DOM stated he was not sure why the temperatures were so high as the water heaters were set at 111 - 115 degrees F. He confirmed the temperatures should not be that high if the water heater is not even set that high. The DOM revealed an outside plumbing service has been out at the facility recently to do some plumbing work but was not sure exactly what they were doing or did. The DOM stated he would have to get with the Nursing Home Administrator to see what type of work they did. On 4/13/2026 at11:19 a.m. the DOM provided a tour of where the water heaters were stored, which was in the back and side of the facility. The DOM (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	opened a door out on the side of the building, which housed a bank of large water heaters. The water heater on the left side of the room was observed with an external water temperature thermometer gauge. It read 111 degrees F. The second water heater on the right side of the room thermometer gauge read 112 degrees F. The DOM confirmed where the water heater temperatures were reading, that it was the normal setting. He was asked if there were any other water heaters and he expressed there was one water heater and booster that was dedicated for laundry room and kitchen. He confirmed the water from that heater does not go to resident rooms or resident spaces. On 4/13/2026 at 3:00 p.m. the DOM followed up to state he forgot about another bank of water heater tanks, which were in a locked space in the facility's main enclosed courtyard. He stated he had just looked at the thermometer gauge, and it read 127 degrees F. He did not remember this water heater before and had just remembered it. The water heater was then confirmed to read water temperature held at 127 degrees F. The DOM confirmed the water from this heater does flow to resident spaces to include community shower rooms and resident room bathroom sinks. He did not have a temperature log for this specific water heater. The DOM did not know why it was set to 127 degrees F. and needed to be set at around 111 - 115 degrees F. On 4/14/2026 at 11:00 a.m. an interview with the Nursing Home Administrator (NHA) revealed the facility has been having plumbing issues and needed parts to help regulate the temperature in one of the water heaters. The NHA provided a plumbing service work order dated 4/13/2026, which was after errant water temperatures were identified by the surveyor. The NHA did not have any plumbing services work orders for review, prior to 4/13/2026. The NHA was not sure why there were water heaters set at 127 degrees F. and confirmed they should not have been set that high. The NHA confirmed she did have a newer director of maintenance and was currently short on maintenance staff. The NHA said individual resident room bathroom sink and shower room water temperatures should have been audited and documented. The NHA was not able to provide any type of evidence this had been conducted for the last three months as requested. The NHA stated the facility had not had any complaints from residents, nor have they had any events of residents being burned by hot water. On 4/16/2026 at 4:00 p.m. the Nursing Home Administrator provided the facility's policy and procedure titled, Monitoring and Recording Facility Hot Water Temperatures for Resident Rooms, Common Areas, and Shower Rooms effective date 11/30/2014.The policy showed; To maintain and control hot water temperatures within the facility to federal and state standards. Hot water temperatures will be maintained to an acceptable level for the safety of the resident and staff.The Procedure section of the policy revealed;1. Hot Water temperatures will be checked daily within the facility by the Maintenance and/or management staff and document on the Facility Water Temperature log. Resident rooms, Shower rooms, and Common areas must be below state requirements.2. The following procedures will be utilized when monitoring hot water temperatures. a. All temperature checks for hot water temperatures must be done utilizing a Dial Stem Thermometer. Infrared and digital thermometers are not to be used. b. Prior to monitoring [NAME] water temperature, all Dial Stem Thermometers must be calibrated. The preferred method to calibrate is the use of ice water in a cup, but placing the thermometer into the ice water and adjusting the needle to 32 degrees F. or 0 degrees C.c. Once the thermometer has been calibrated, select a resident room at the beginning of each corridor.1. Let the hot water run from the faucet for 3 to 5 minutes. 2 . Insert the stem at an angle, about 2 inches into the stream of running water where as much of the stem is in the water flow as possible. 3 . The temperature should register on the thermometer in about 10 to 15 seconds. Record temperature onto temperature log.1. The following procedures will be implemented, by the Maintenance staff, if a hot water temperature is found to be above 110 degrees F., the acceptable level for resident rooms, showers, and common areas: (If high temperature is found on the weekend or holidays, immediately call maintenance staff).a. If water temperatures are above maximum degree requirements in resident rooms, common areas, or shower rooms, immediately turn off the hot water to these areas and adjust the hot water mixing valve. Immediately notify the E.D., DCS, and staff of effected area where hot water is turned off. Follow Lock Out/Tag Out procedure for turning off hot water at the source.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews and record review the facility failed to ensure the medication error rate was less than 5.00%. Forty-two medication administration opportunities were observed and 16 errors were identified for three resident (#6, 138 and 95) out of seven residents observed. These errors constituted a 38.1% medication error rate.Findings included: On 4/15/2026 at 8:26 a.m., during medication administration for Resident #95, an observation was made of Staff D, Registered Nurse (RN) who pulled the following medications: Ipratropium bromide and albuterol 0.5mg/3 ml (milligrams /milliliters) and Budesonide 0.25mg/2 ml. Staff D, RN stated for Resident #95 she normally saves her for last because she has at times refused her medications and stated she had two nebulizer medications to give. Resident #95 was amiable for her medications. An observation was made of Staff D, RN opening both plastic tubes each containing the two separate nebulizer medications, pour the medications into the nebulizer vial, connect the vial containing both nebulizer medications to a face mask, hooked the tube to the nebulizer machine, turn the machine on and placed the mask over the resident's face to begin the administration of the medications. An interview was conducted with Staff D, RN, regarding the administration of both medications at once. Staff D, RN stated she combined the two medications to save time and did not think there was a policy or contraindication not to combine the medications. An observation was made of the Staff D, RN removing the facemask, washing the mask and nebulizer and left to air dry. Resident D, RN did not rinse Resident #95's mouth with water after the treatment. On 4/15/2026 at 9:31 a.m., during medication administration for Resident #138 an observation was made of Staff E, Licensed Practical Nurse (LPN) who pulled the following medications: Venlafaxine ER 150 mg one tablet, Empagliflozin 25 mg one tablet, and acetaminophen 325 mg two tablets. An observation was made of Staff E, LPN crushing all three medications together and pouring the crushed pills together in one medicine cup. An observation was made of Staff E, LPN adding water to the medicine cup to dissolve the medications. Staff E, LPN paused Resident #138's enteral pump, disconnected enteral tube connected to Resident #138, checked for residual, connected a large syringe to the gastrostomy tube and added water as an initial flush. Staff E, LPN was observed pouring the medication cup with the crushed dissolved medications into the syringe connected to the gastrostomy tube. Staff E, LPN allowed the medication to flow via gravity with an observation made of a large number of remaining medications in the medicine cup. Staff, E, LPN added more water and repeated the cycle four to five times until the medicine cup was empty. An interview was conducted with Staff E, LPN regarding adding all crushed medication at once. Staff E stated she was told it was okay to crush all medications together. Staff E, LPN, stated she did not administer Resident #138's prescribed medication Nerlynx yesterday or today because it was not available. She stated she called the pharmacy yesterday for a delivery and she will call today. Staff E called over Staff C, LPN/Unit Manager (UM), to inform him of the missing medication Nerlynx. Staff E was instructed by Staff C LPN/UM to notify the physician and said he would follow up with pharmacy.On 4/16/2026 at 9:35 a.m., an interview was conducted with Staff G, RN who stated she did not realize Resident #6 was on an antibiotic because it was never discussed in morning report with the off coming nurse. On 4/16/2026 at 9:39 a.m., an observation was made of the Assistant Director of Nursing (ADON) providing an unidentified antibiotic to Staff G,RN while she was at her 100-hallway medication cart. Staff G paused administration to the 100 hallway and walked over to the 300-hallway medication cart to provide Resident #6 his medications, including his antibiotic. On 4/16/2026 at 9:41 a.m., during medication administration for Resident #6, an observation was made of Staff G, RN who pulled the following medications:Zince 50 mg one tablet, Senna 8.6 mg one tablet, Tamsulosin hydrochloride 0.4 mg two tablets, Potassium chloride 20 mEq (milliequivalents) one tablet, Folic acid one milligram one tablet, Gabapentin 300 mg two tablets, Buspirone hydrochloride 30 mg one tablet, Pantoprazole 40 mg one tablet, Metoprolol tartrate 25 mg one tablet, Lisinopril 5 mg one tablet, Ceftriaxone one gram in 100 ml of normal saline and Clopidogrel 75 mg one tablet.On 4/16/2026 at (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9:48 a.m., Staff G, RN had requested an unidentified Certified Nurse Assistant (CNA) to assist her with obtaining a blood pressure for Resident #6. On 4/16/2026 at 9:53 a.m., an observation was made of an unidentified CNA wearing a gown and gloves in Resident #6's room and stated the blood pressure was 89/58. An observation was made of Staff G, RN requesting a manual cuff from the unidentified CNA. The CNA exited the room and Staff G, RN was observed flushing Resident #6's left midline with normal saline. Staff G, RN hung the bag of Ceftriaxone on an IV (intravenous) pole and flushed the IV tubing with the antibiotic. Staff G exited the room and requested another unidentified CNA to locate the unit manager to assist in locating a manual cuff. On 4/16/2026 at 10:08 a.m., an observation was made of Staff G, RN cleaning a manual cuff with a three-minute kill time antiseptic commercial wipe. At 10:11 a.m., Staff G, RN obtained a manual cuff blood pressure reading of 90/60 and informed the resident she would be holding his blood pressure medications this morning and she would inform his physician. An observation was made of Staff G, RN, informing the resident she would be back with his Plavix. At 10:14 a.m., Staff G, RN provided Resident #6 his medications and began his infusion of his antibiotic. At 10:20 a.m., blood pressure medication was wasted and Clopidogrel (Plavix)75 mg was pulled from the electronic medication dispenser machine. At 10:25 a.m., Clopidogrel 75 mg was administered.On 4/16/2026 at 10:30 a.m., an interview was conducted with Staff F, RN and Staff G, RN. Both nurses were assigned half the 300 hallway, and both admitted they had not started their medication administration for the 300 hallway. On 4/15/2026 at 11:41 a.m., a telephone interview was conducted with the facility's pharmacy consultant. The pharmacist stated Resident #138's Venlafaxine ER (extended release) should not have been crushed. The pharmacist stated for Resident #95, it is not best practice to combine the two medications for her nebulizer treatments. The pharmacist stated it is best to provide one at a time with a three-to-five-minute interval in between the medications. The pharmacist stated it is best to provide the medication first like the Albuterol followed by the medication with the steroid in it. On 4/16/2026 at 10:56 a.m., an interview was conducted with the Medical Director (MD) for the facility. The MD stated it would be best practice to separate the two medications for Resident #95's breathing treatments. The MD stated the Budesonide will get foamy in the chamber during the aerosolization of the medication, thus, the Albuterol may not get absorbed as it should. The MD stated best practice is to separate the two medications. The MD stated although Resident #138 was not her resident, the facility knows they can come to her for assistance with obtaining specialty medications. The MD stated she was unaware of assistance needed for Resident #138's Nerlynx and will have this issue of obtaining her medication, Nerlynx, resolved. The MD stated she was not sure if the medication could be crush but she will follow up with the specialty pharmacy to resolve the delayed medication. Review of a website literature search for the medication of Budesonide accessed on 4/16/2026 showed the following: https://www.drugs.com/pro/budesonide-inhalationsuspension.html#s-43685-7 5.1 In clinical trials with budesonide inhalation suspension, localized infections with Candida albicans occurred in the mouth and pharynx in some patients. The incidences of localized infections of Candida albicans were similar between the placebo and budesonide inhalation suspension treatment groups. If these infections develop, they may require treatment with appropriate local or systemic antifungal therapy and/or discontinuance of treatment with budesonide inhalation suspension. Patients should rinse the mouth after inhalation of budesonide inhalation suspension. 2.2 The effects of mixing budesonide inhalation suspension with other nebulizable medications have not been adequately assessed. Budesonide inhalation suspension should be administered separately in the nebulizer.On 4/16/2026 at 11:20 a.m., an interview was conducted with the Director of Nursing (DON). The DON had stated the two medications to be delivered via nebulizer for Resident #95 should have been separated. The DON stated medications should not be crushed if they are an extended-release medication and medications crushed should be delivered separately unless there was an order to combine the crushed medications. The DON stated medications delivered at 10:00 a.m. would be considered late. The DON stated there is a window for medications, an hour before and/or one hour after the scheduled (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication time would be acceptable. The DON was aware of the 300-hallways delay in medications.A review of the facility's policy and procedure titled, Medication-Oral Administration of, revision date 8/15/2019, showed the following procedure: Review physician's orders Review the MAR (Medication Administration Record) or EMAR (electronic Medication Administration Record) should there be any uncertainties verifying the MAR or EMAR with the physician's order sheets and seek clarification as indicated. Refer to pharmacist if unsure if a medication should be crushed.A review of the facility's policy and procedure titled, Medication-Administration Via Enteral Tube, revision date 3/06/2019, showed the following procedure: If not a liquid medication, and if able to be crushed, finally crush each medication with pill crusher or open capsules and pour powder into a medication cup with 5 to 15 cc (milliliters) of water and dissolve. If liquid, pour the correct amount per the physician order into a medication cup. There should be one medication per cup. DO NOT MIX MEDICATIONS unless there is a specific physician order to do so. Consistency of solution should be able to pass easily through a tube. NOTE: if medication cannot be crushed and is unavailable in liquid, notify physician. Pour one, individual liquefied medication in the syringe, and allow gravity to drain medication into the stomach. Followed by at least 15 cc (or physician order if different) of water in between each medication. NOTE: Keep the syringe partially filled to prevent excess air from entering the stomach.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review and interview, the facility failed to ensure infection control policies and procedures were followed related to the use of PPE (Personal Protective Equipment) and Hand Hygiene (HH), for three residents (#16, #85 and #6) out of three residents sampled for contact precautions.Findings included: On 04/15/2026 at 11:07 AM, Staff M, Licensed Practical Nurse (LPN)/ Unit Manager (UM), was observed entering the room of Resident #16 without wearing any personal protection equipment (PPE). Staff M walked about three feet into Resident #16's room, assisted Resident #16 out of her room via wheelchair, and positioned the resident on the outside of the room door, across from the nurse's station. Staff M then went back into Resident #16's room to remove the bedside table and positioned the bedside table next to Resident #16 outside of the room. Staff M was observed not wearing any PPE. Staff M was not observed to perform hand hygiene prior to or after making contact with Resident #16's person or personal belongings. Record review for Resident #16 revealed an admission date of 3/3/2026 with medical diagnoses to include extended spectrum beta lactamase (ESBL), unspecified, resistance to multiple antibiotics, and unspecified Escherichia coli (E. Coli). Review of the summary report for Resident #16 dated 4/16/2026 revealed active orders for isolation type- enhancer barrier precautions for history of ESBL, wounds. Review of the care plan report for Resident #16 initiated on 2/16/2026, revealed a focus - Resident #16 required enhanced barrier precautions related to known Center for Disease Control (CDC) Multidrug-Resistant Organisms (MDROs) infection/colonization as evidence by ESBL/urine Clostridioides difficile (C. diff), wounds. Interventions included staff to wear enhanced barrier precaution personal protective equipment (PPE) when providing high contact direct care activities. The care plan report for Resident #16 also revealed a focus of having C. diff. Interventions included contact isolation: wear gowns and masks when changing contaminated linens. Place soiled linens in bags tightly before taking to laundry and disinfect equipment before it leaves the room. An interview was conducted with Staff M, LPN/UM, on 04/16/2026 at 4:02 PM. The interview revealed that Resident #16 was under contact precautions due to a diagnosis of C. diff. Staff M said staff should wash hands with soap and water prior to entering Resident #16's room and upon exiting the room. Staff M said this hand hygiene protocol should be followed any time staff enters the room because they may not be aware of what the resident has touched within the room. Staff M reported providing education to staff on infection control and prevention on 04/15/2026. Staff M reported monitoring infection prevention and control practices while staff is on the floor providing resident care, if protocol is observed not being followed appropriately, verbal education is provided to staff immediately. If there are further instances of not following appropriate infection prevention and control practices, then written education is provided to staff. An interview was conducted with Staff O, Certified Nursing Assistant (CNA), on 04/16/2026 at 2:51 PM. Staff O who was assigned to Resident #16 reported receiving education on infection prevention and infection control every other day. Staff O said the education included appropriate hand hygiene protocol, enhanced barrier precaution protocol, and contact precaution protocol. Education provided by facility management informed staff to perform hand hygiene prior to and after providing resident care in addition to putting on gloves and a gown before entering or leaving a resident's room when (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they are under contact precautions. An interview was conducted with Staff N, CNA on 04/16/026 at 3:01 PM. The interview revealed that Staff N received education during the previous week about infection prevention and control. Staff N said the education included appropriate hand hygiene protocol, enhanced barrier precaution protocol, and contact precaution protocol. Education provided by facility management informed staff to perform hand hygiene prior to and after providing resident care in addition to putting on gloves and a gown before entering or leaving a resident's room when they are under contact precautions. Staff N reported providing toileting and incontinence care for Resident #16 during previous shifts. On 4/13/2026 at 10:17 AM an observation was made of an unidentified Certified Nursing Assistant (CNA) entering Resident #85's room without a gown or gloves on. A Contact Precautions sign was observed outside of Resident #85's door. The unidentified CNA asked another CNA in the hallway for assistance with Resident #85. The other unidentified CNA was observed donning a gown and gloves prior to entering the room. An interview was conducted with the CNA entering the room who stated the CNA in the room should have donned a gown and gloves on. On 4/14/2026 at 12:55 PM an observation was made of an unidentified CNA entering Resident #85's room without a gown or gloves. The Director of Nursing (DON) observed the same observation and stated the CNA should be gowned and wear gloved upon entering the resident's room. The DON stated Resident #85 was new to Contact Isolation. On 4/16/2026 at 10:11 AM an observation was made of Staff G, Registered Nurse (RN) during medication administration. Staff G, RN entered Resident #6's room without donning a gown and gloves to administer the resident's intravenous medication on two separate occasions. Resident #6 had an Enhanced Barrier Precaution sign on his door. On 4/16/2026 at 1:20 PM an interview was conducted with Staff G, RN who agreed she should have worn a gown when administering Resident #6's intravenous antibiotic. A record review of Resident #85 's physician orders showed an order for Isolation type-Contact precautions for ESBL (Extended-Spectrum Beta Lactamase) /Urine, ordered 4/10/2026. A record review of Resident #6's physician orders showed an order for Isolation type-Enhanced Barrier Precautions for MRSA, foley catheter, Wound, every shift, ordered 4/03/2026, and an order for Enhanced Barrier Precautions- Midline every shift, ordered 4/16/2026. Review of a facility policy titled, Infection Prevention and Control Program, revised October 2018, revealed the elements of the invention prevention and control program consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection and employee health and safety. According to the policy, important facets of infection prevention include: (1) identifying possible infections or potential complications of existing infections; (2) instituting measures to avoid complications or dissemination (3) educating staff and enduring that they adhere to proper techniques and procedures; (4) communicating the importance of standard precautions and cough etiquette to visitors and family member; (5) enhancing screening for possible significant pathogens; (6) immunizing residents and staff to try to prevent illness; (7) implementing appropriate isolation precautions when necessary; and (8) following established general and disease-specific guidelines such as those of the CDC. Review of a facility policy titled, Policies and Procedure Subject: Enhanced Barrier Precautions, with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an effective date of 09/01/2022 revealed enhanced barrier precautions (EBP) is used to reduce the spread of MDROs among residents by utilizing gloves and gowns for high contact resident care activities.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to accommodate a resident's right to communicate in the language of their choice for one resident (#18) of one observed, and failed to provide a resident with a bed that met his height,comfort and furnishings requirements for one resident (#5) of one resident observed.Findings included: During a facility tour 04/14/2026 at 10:51 a.m., Resident #18 was observed in bed. The resident did not respond to the interview and was observed pointing and using hand gestures in an attempt to express themselves. A family member who was in the room stated the resident does not speak English and that they spoke Arabic language. During this observation, there were no signs posted to direct anyone on this resident's preferred communication method. Review of the admission Record revealed Resident #18 was admitted to the facility on date 4/26/2025, with diagnoses to include cerebral infarction due to thrombosis of right anterior cerebral artery, hemiparesis following cerebral infarction affecting left non-dominant side and difficulty in walking. Review of Resident #18's care plan date initiated 04/28/2025 and revised on 01/28/2026 showed he had an interpretation need related to primary language Arabic. The care plan goals showed Resident #18 will communicate via an interpreter, date initiated 04/28/2025, target date 05/27/2026. The care plan interventions showed Resident #18 has translation needs, (needs an interpreter), Dated initiated 04/28/2025. On 4/15/2026 at 11:15 a.m. an interview was conducted with Staff K, Certified Nursing Assistant, (CNA). Staff K said Resident #18 spoke Arabic. Staff K stated if a resident spoke a different language they try to understand them. Staff K said Resident #18 communicates through hand gestures because he did not understand English. Staff K stated he tried using a translation App (application), but it was not helping. On 4/15/2026 at 2:13 p.m. an interview was conducted with Staff E, Licensed Practical Nurse, (LPN/ Unit Manager. Staff E stated Resident #18 speaks Egyptian Arabic. The staff member said Resident #18, is a pointer and he uses gestures to express what he needs. The staff member said the resident understood English, but if it got to the point where he did not understand English, Staff E said they would call the language line. On 4/15/2026 at 10:29 a.m. an interview was conducted with Staff Q, CNA. This staff member said Resident #18 spoke Hindi. The staff member said there was no one at the facility who spoke his language. The Staff member did not identify how they could effectively communicate with Resident #18.On 4/15/2026 at 1:30 p.m. an interview with Staff H, LPN, was conducted. She stated the facility uses the communication line to communicate with residents who spoke a different language. During this observation and interview, the nurse was observed trying to call the communication line, but it was out of service. The nurse did not know how else to interpret for the resident. On 04/15/2026 at 1:42 p.m. an interview was conducted with Staff E, LPN/Unit manager. He stated they had two people that spoke a different language. He stated they use the [Name of communication company] line to communicate with the residents. Staff E stated that communication line was what the facility uses. Staff E confirmed the line was not operable at the time. On 04/15/2026 at 1:30 p.m. an interview was conducted with Staff E, LPN. She stated the facility uses a communication line. She stated she never had to use it because Resident #18 uses gestures when she communicates with him. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/15/2026 at 1:58 p.m. an interview was conducted with the Director of Nursing (DON). She stated usually they would coordinate with therapy to get a communication board to assist residents who spoke a different language. The DON said in addition, they had a translation line for staff to use to communicate with the residents who spoke a language other than English. The DON said their main source of communication was the communication line. She stated she was not aware the phone numbers to the communication line were not working. The DON said, This is the first time it has been brought to my attention that the communication language line in the facility is not working. Review of the facility policy titled, Language Access Plan, revised date 9/1/2023 showed Purpose, section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, disability. Procedure: 4. Effective communication with Limited English Proficiency [LEP] individuals requires the Care Center to have language assistances services in place. The Care Center offers communication in the following forms: a. Oral communication: assistance service may come in the form of in-language communication (bilingual staff member communicating directly in an LEP person's language), or interpreting. 2. On 4/13/2026 at 8:50 a.m., 1:00 p.m., 4/14/2026 at 8:30 a.m., 2:00 p.m., 4/15/2026 at 8:50 a.m., 12:45 p.m., and on 4/16/2026 at 8:15 a.m. and 3:45 p.m., Resident #5 was observed in his room, lying in bed with his bed elevated approximately 25 – 35 degrees. He was noted during each observation covered with sheets and blanket, but with both of his legs and feet exposed and uncovered. Resident #5 was observed utilizing a large and wide bariatric bed. Resident #5 was observed tall in height and with both of his feet pressed up against the inside surface of the foot board. The foot board was extended out from the foot end of the mattress approximately six to seven inches, not leaving enough room for the resident to have his feet not pressing against the foot board. During an interview and observation with Resident #5 on 4/13/2026 at 8:50 a.m., he stated he was receiving Hospice services and that Hospice had provided him with this bed upon his request for a larger bed. Resident #5 stated he was in need for a longer mattress not a wider mattress. Resident #5 revealed he had spoken to various staff to include aides, nurses, social worker, and dietary staff that he needed another bed and the one he used was not long enough. Resident #5 was observed with wounds on both of his feet and ankles that were wrapped with dressings. On 4/15/2026 at 1:45 p.m. during an observation and interview, Resident #5 was in his room and lying visiting with a family member who stated they did not believe the bed was long enough. Resident #5's family member said she did not know why they provided him with such a wide bed, but not long enough. Resident #5's foot board was observed extended out from the end of the foot of the bed around one and half to two feet. the residents feet were pressed up against the surface of the foot board and turned towards the right side of the bed. Resident #5's head was positioned approximately less than eight inches from the end of the head of the bed. Resident #5 stated he did not feel right in such a wide bed and did not feel right with the bed not being long enough for his height. Resident #5 and the family member both felt the facility did not maintain his dignity as far as his bed size was concerned. On 4/14/2026 at 10:00 a.m. an interview with Staff A, LPN and Staff B, LPN who both had Resident #5 on their assignment, confirmed he had a large wide bed which was not long enough to meet his height comfort. Staff A stated confirmed both of his feet were pressing up against the foot board surface and stated he should have a longer bed. Staff A and B did not remember if Resident #5 and or the family member had asked for a longer bed. Staff A stated even though she did not remember Resident #5 complaining about the bed, this should have been something direct care staff should have (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	caught and brought it up to the Director of Nursing (DON), or Nursing Home Administrator's (NHA) attention. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE]. Review of the advance directives revealed the resident was his own decision maker. Review of the diagnosis sheet revealed diagnoses to include but not limited to: Orthopedic aftercare, Low back pain, DMII (Diabetes Mellitus, II), Muscle wasting, Abnormalities of gait, and Anxiety. Review of the most current significant change Minimum Data Set (MDS) assessment dated [DATE] revealed; (Cognition/Brief Interview Mental Status (BIMS) score of 13 out of 15, which indicated Resident #5 was able to make his medical and daily decisions. On 4/16/2026 at 1:00 p.m. an interview with the NHA and the DON confirmed Resident #5 received Hospice services and when he was admitted to the facility, he had requested a larger bed. The NHA stated Hospice services replaced his bed with a bed from their agency, which was a much larger bed for him. She confirmed after observing this past week, Resident #5 had a wide bariatric bed. The NHA said they did not have a longer bed to meet his height and comfort needs. The DON confirmed they should have caught this and reached out to Hospice for a longer bed not a wider bed. The Nursing Home Administrator was requested to provide a policy and procedure related to bed size accommodation. A policy was not provided for review.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to notify the physician and family of a change in condition after a new skin condition was identified for one resident (#2) out of one resident observed.Findings included: Review of a Weekly Skin Integrity Assessment on 3/13/2026 and 3/19/2026 showed Resident #2 had bilateral lower arm bruises.Review of Progress Notes for Resident #2 did not show notification to family, physician, or the administration about the bilateral lower arm bruises found during the skin assessments on 3/13/2026 and 3/19/2026. Review of the Resident #2 information record dated 4/17/2026 showed Resident #2 was originally admitted [DATE] and readmitted on [DATE] with the diagnoses including Non-ST Elevation (NSTEMI) Myocardial Infarction, dementia, depression, post-traumatic stress disorder and chronic kidney disease.On 4/15/2026 at 2:41 p.m. an observation and interview were conducted with Staff E, Licensed Nurse Practitioner (LPN) about the discoloration on Resident #2's right forearm. Staff E stated they were not aware of this as they had been gone for the past month and it was their second day back. Staff E observed the discoloration and stated they did not know what the discoloration was, but they would review the facility's health information system. Staff E reviewed the record and upon becoming aware of the documented skin assessments completed on 3/13/2026 and 3/19/2026, Staff E, LPN stated they did not complete that assessment. On 04/16/2026 at 5:48 p.m. an interview was conducted with Staff C, LPN/ Unit manager. Staff C stated they did not hear or know about the discoloration on the Resident #2's arm until yesterday (04/15/2026). Staff C stated normally when a discoloration occurs, Staff C will note this in the system and the wound care nurse would examine it. Staff C stated discoloration was to be reported to the physician and family, and then enter the information into the health system, which would have triggered a change in condition. Staff C stated this would then be followed up by the unit manager to ensure treatments were put in place. Staff C stated Resident #2 tended to rub his arm on the bed rails often as this was a common behavior caused by frequent itchiness. Staff C could not find the documentation of this behavior in the care plan.On 4/16/2026 at approximately 10:00 a.m., an interview was conducted with the facility administration staff. They said the red discoloration on Resident #2's arms were from his behavior of rubbing his arms on the bed rail as the resident has chronic itchy skin and tends to self-inflict scratches. The administration did not provide a copy of the care plan with the stated behavior.Review of a facility policy and procedures titled Notification of Change in Condition, Revised 12/16/2020 showed a policy: The Center to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is a change in the status or condition.Procedure:The nurse to notify the attending physician and Resident Representative when there is a(n):- Accidents- Significant change in the patient/resident's physical, mental, or psychosocial status- Notify the patient/resident and the resident representative of the change in condition.- Document notification in the medical record.- Document resident/patient change in condition on 24-Hour Report- Complete SBAR as indicated

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview and review of the facility's housekeeping procedures, the facility failed to ensure shower rooms were maintained in a sanitary manner in one shower room (Zone One East) out of two shower rooms observed.Findings included: On 04/16/2026 at 2:48 p.m., the shower room in zone one East wing was observed to have black biological growth on the grout in between the tiles on the shower walls in addition to the grout in between the tiles on the shower floors. The black biological grown observed was observed on the shower walls and the floor upon entrance into the shower in addition to the floor perpendicular to the wall afore mentioned. An interview was conducted on 04/16/2026 at 3:53 p.m. with the housekeeping/laundry manager. The interview revealed the housekeeping staff was responsible for maintaining the cleanliness and sanitization of the shower rooms throughout the facility. The housekeeping/laundry manager stated housekeeping staff disinfects shower equipment, maintains the cleanliness of the shower room walls and floors, and removes trash from the shower rooms. The housekeeping/ laundry manager described the process of cleaning shower rooms as follows: Housekeeping staff sweeps the floors of shower room, sprays disinfectant on the shower room walls, floors, and equipment, allows the disinfectant chemical to remain on all surfaces for a minimum of five minutes, and then removes the chemical from equipment and walls with a cloth. The manager stated the disinfectant is mopped from the floors of the shower room using the same disinfecting chemical. The housekeeping manager stated they were responsible for verifying the cleanliness and sanitization of each shower room every morning. The manager stated if errors were observed, housekeeping staff would be notified to remedy the errors. During a tour on 04/16/2026 at 3:56 p.m. the shower room in zone one east wing was observed with the housekeeping manager who confirmed the observation of black biological growth on the walls and floor of the shower room. The housekeeping manager was uncertain of the department responsible for ensuring there was no biological growth in the shower room but believed it may have been the responsibility of the maintenance department.On 04/16/2026 at 4:10 p.m. an interview and observation was conducted with the Director of Maintenance (DOM) revealing housekeeping staff were responsible for maintaining the cleanliness and sanitization of the shower rooms. The DOM observed the black biological growth in the shower room and said the growth should be cleaned and removed by housekeeping.Review of a facility policy titled, Restroom Cleaning, revised 2/1/2025 revealed [name of contracted provider] is committed to Providing a safe clean and hygienic environment for residents, staff, and visitors in accordance with regulatory guidance and industry-based practices. Walls are generally considered low touch surfaces. Wall washing frequency will vary depending on the location (common areas, residents/patient care areas, isolation rooms). Between scheduled cleanings, walls will be spot cleaned when they are visibly soiledReview of a facility document revised 1/2/2026, titled, Job classification - Housekeeping -1, revealed a daily work assignment showing the following expectations:Clean the soiled/Clean Utility Linen & Shower Room following the 5-step method of cleaning. The 5 Step Method of cleaning showed:1) empty trash, 2) disinfect horizontal surfaces, 3) spot clean vertical surfaces 4) dust mop floor, 5) damp mop floor. (Photographic Evidence Obtained)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, records and policy review, the facility failed to ensure the level I Preadmission Screening and Resident Reviews (PASRRs) were completed accurately for two residents (#17 and #18) out of eight residents sampled.Findings included:Review of an admission Record dated 4/16/2026 revealed Resident #17 was admitted to the facility originally on 12/18/2025 with diagnoses to include but not limited to bipolar disorder, unspecified, major depressive disorder, recurrent, moderate, generalized anxiety disorder, bipolar disorder, current episode manic without psychotic features, and Parkinson's disease.Review of Resident #17's level I PASRR dated 12/17/2025, showed under screening decision making in section A only bipolar disorder was checked and no other mental illnesses were checked. The review showed the level I PASRR was incomplete, and a level II was not submitted for consideration.Review of an admission Record dated 04/15/2026 revealed Resident #18 was admitted to the facility on [DATE] with diagnoses to include but not limited to major depressive disorder, recurrent, moderate, other specified anxiety disorders, and primary insomnia.Review of Resident #18's level I PASRR with no date showed in section A, a blank PASRR and there were no mental illnesses checked. The review showed the level I PASRR was incomplete, and a level II was not submitted for consideration.On 04/15/2026 at 5:45 p.m. an interview was conducted with the Social Services Director (SSD). She stated she had worked at the facility since June of 2025. She stated she does not complete Preadmission Screening and Resident Reviews (PASRRs), because she does not have a master's degree in social work. The SSD stated the PASRRs are completed by a Registered Nurse. She stated when the new admissions comes, their PASRRs are evaluated by the admission team. The PASRR is placed on the chart. She stated she looks at the PASRR to see what diagnoses the resident have at the time, then if there is any discrepancy, she would notify the Interdisciplinary team (IDT) that the PASRR need to be updated. She stated Resident #17's and #18's Level I PASRRs were incorrect and should have been updated to reflect their mental health diagnoses. She stated she did not review the two resident's PASRRs and had not notified the IDT team that their PASRR's needed to be updated. On 04/16/2025 at 10:00 a.m. an interview was conducted with the Director of Nurses, DON. The DON stated she expects all level I PASRR to be reviewed, updated and completed accurately by the Interdisciplinary team. Review of a policy titled Preadmission Screening and Resident Review (PASRR) revision date 11/08/2021 showed - Policy: The center will assure that all Serious Mental (SMI) and intellectually Disable (ID) residents receive appropriate pre-admission screening according to Federal/ State guidelines. The purpose is to ensure that the residents with SMI or are ID receive the care and services they need in the most appropriate setting. Procedure: 1. It is the responsibility of the center to assess and assure that the appropriate preadmission screenings, either level I or Level II, are conducted and results obtained prior to admission and placed in the appropriate section of the resident's medical record. 7. Social Services will be responsible for coordinating significant change updates of these screenings conducted by the appropriate agency. These results, along with the results from previous years will be kept in the appropriate sections of the resident's records.

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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 observations, record review and interviews, the facility failed to implement the care plan related to fall interventions for one residents (#16) of two observed and failed to follow the resident's care plan for protective heel boots for one resident (#108) of one observed. Findings included: 1. On 4/13/2026 at 10:37 a.m. Resident #16 was observed in her room lying flat in bed. She was noted with fall floor mats on either side of her bed. The fall floor mat on the right side of the bed was observed in a folded position and positioned against the wall, away from the bed. Further observations revealed the call light was placed on the back left side of the pillow, out from her reach. Resident #16 confirmed she would not be able to reach her call light should she need it. The same observations were made on 4/14/2026 at 1:24 p.m. and on 4/16/2026 at 9:03 a.m. On 4/13/2026 at 10:40 a.m. an interview and observation with Staff B, Certified Nursing Assistant (CNA) confirmed Resident #16 was in bed and lying on her side and with the call light placed on her upper pillow, and above her head. Staff B confirmed Resident #16 would not be able to reach the call light if she needed to use it. Resident #16 was asked if she knew where her call light was and she attempted to reach around for it and then gave up. She said, don't know. Staff B stated all residents are to have call lights placed within their reach while in bed no matter if they were able to use them or not. Staff B, CNA confirmed the fall floor mat on the right side of the bed was folded and not placed appropriately at bedside. She was not sure what the resident's needs were with relation to the fall floor mats. Staff B stated she believed if a resident had fall floor mats in the room, they needed to be placed on the floor at bedside and not off to the side of the room. On 4/14/2026 at 10:00 a.m. an interview was conducted with a Licensed Practical Nurse (LPN), Staff A, who confirmed Resident #16 was in her room and lying in bed. Staff A observed and confirmed Resident #16 could not reach her call light/call light cord, as it was out from her reach and hanging over the back of her bed. Staff A revealed as far as she knew, Resident #16 used the call light and stated even if she did not, the call light is to be placed within her reach, while in bed. Review of the medical record revealed Resident #16 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include but not limited to age related Osteoporosis, Unspecified fracture of the lower end of right radius, Muscle wasting, Abnormalities of gait, Cognitive communication deficit, History of falls, Anxiety, Major depression.Review of the most current Medicare 5-day Minimum Data Set (MDS) assessment dated [DATE], revealed; (Cognition/Brief Interview Mental Status (BIMS) score of 9 out of 15, meaning the resident was moderately impaired. Review of the current care plans with a next review date 6/2/2026 revealed the following but not limited to: Resident has had multiple falls and an actual fall with a fracture, with interventions to include but not limited to: Keep the bed in low position, Bilateral floor mats. Resident is at risk related to confusion, gait/balance problems, unaware of safety need, with interventions to include but not limited to: Be sure the resident's call light is within reach and encourage the resident to use it. On 4/16/2026 at 1:00 p.m. an interview with both the Nursing Home Administrator (NHA) and the Director of Nursing (DON) confirmed Resident #16 is able to use her call light and should always have her call light placed within her reach while she is in bed. Both were not aware of her having any behaviors in the past of her removing the light/cord from her reach. They also confirmed she does utilize fall floor mats on both sides of the bed and when she is in bed and stated the mats should be appropriately placed on either side of the bed. 2. On 04/13/2026 at 11:13 a.m., and 12:49 p.m., and on 04/14/2026 at 11:07 a.m., and 4:14 p.m., and on 04/15/2026 at 11:23 a.m., Resident #108 was observed in bed with no heel boots on. Resident #108 heel boots were inside the closet. Review of Resident #108's medical record revealed an admission (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	date of 8/23/2015 with diagnoses to include adjustment disorder with mixed anxiety and depressed mood, muscle weakness (Generalized), foot drop - left foot, right foot. Review of Resident #108's Care Plan Report, date initiated: 11/17/2018, Revision dated 01/08/2025 showed the focus Resident #108 ADL (Activity of living) self-care performance deficit r/t (related to) previous CVA (cerebrovascular accident) with left sided weakness, impaired cognition, impaired communication and foot drop. Assistance needed with all ADL's. The goal showed Resident #108 will maintain current level of function through the review date. Interventions included: -Don/Doff bilateral ankle flexion boots for contracture management as ordered, Date initiated: 09/06/2023 On 04/15/2026 at 1:01 p.m., an interview was conducted with Staff P, CNA. She stated Resident #108 was to have boots on for two to three hours a day. Staff P stated the physical therapist (PT) said the resident was not on caseload and needed to check with the PT director. Staff P revealed Resident #108's boots were in the closet. On 04/15/2026 at 1:30 p.m., an interview was conducted with Staff H, LPN. She stated she was not aware the heel boots were not being put on Resident #108. She said that the whole time the resident is in bed, the expectation would be to have the heel boots on the whole time. She stated it is the nurse's and certified nurses assistants responsibility to ensure a resident's care plan are followed and someone should have noticed the boots were not on while cleaning and repositioning Resident #108. On 04/15/2026 at 1:45 p.m., an interview was conducted with Staff C, LPN/Unit manager (UM). He stated when a resident has a care plan to have heel boots, the expectation was for the heel boots to be on at all times while the resident is in bed. Staff C said if the heel boots are not available, then the staff should make sure the resident heels are offloaded using pillows. Staff C said if a resident is refusing, then it should be documented in the progress notes and that they respect residents' wishes. On 04/14/2026 at 1:58 p.m., an interview was conducted with the DON. The DON stated if a resident is care planned to have heel boots/protective boots, her expectation are the heel boots should be put on as ordered. She stated if a resident is refusing, it is to be documented daily in charts. Review of the facility policy titled, Plans of Care effective date 11/30/2014, revealed, Policy - An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements.The procedure section of the policy showed: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 baseline plan of care within 48 hours of admission that includes, but not limited to, initial goals based on the admission orders, physician's orders, dietary orders, therapy services, social services, PASAR recommendations, if applicable, and other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs are met appropriately until the Comprehensive plan of care is completed. Develop and implement an individualized Person-Centered comprehensive plan of care by the interdisciplinary team that includes but 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 participation of the resident and the resident's representative(s) within seven (7) days after completion of the comprehensive assessment (MDS).

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	105951	A. Building B. Wing	04/16/2026

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Aviata at Oakfield	1465 Oakfield Dr 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to review, revise and update interventions for a fall care plan to ensure safety and prevent accidents for one Resident (#18) out of five residents sampled. Findings included: Review of an admission Record dated 04/15/2026 revealed Resident #18 was admitted to the facility on [DATE] with diagnoses to include but not limited to cerebral infarction due to thrombosis of right anterior cerebral artery, muscle wasting and atrophy, not elsewhere classified, unspecified, difficulty in walking, not elsewhere classified, and generalized muscle weakness.Review of a Situation, Background, Assessment, and Recommendation, (SBAR) Communication Form, and Progress Note for Registered Nurses, RN's/ License Practical Nurses, LPN/ License Vocational Nurses, LVN, dated 3/8/2026 showed a change in condition due to a fall. At 8 p.m., resident observed lying on the floor near his bed and wheelchair. Review of an SBAR Communication Form, and Progress Note dated 2/2/2026 showed a change in condition due to a fall. The recommendations for the primary clinician showed: neuro checks, medication for anxiety. Review of a focus care plan showed, (Resident #18) has had an actual fall with no injury, laying on floor next to bed wrapped in covers, lying on floor next to bed, Fall (Resident #18) attempted to ambulate while [family member] in room, 4:15 AM fall. Resident laying on floor next to bed, non-sitting on floor head resting on bed, fall observed next to bed no injury, fall, no injury noted unwitnessed, fall from Wheel Chair, fall no injury noted witnessed fall from wheel chair, fall observed next to bed no injury, slid out of wheel chair at nurses station, slid out of Wheel chair in his room. is noted to attempt to get up out of chair on multiple occasions thus resulting in falls. Dated initiated 07/15/2025 revised on 02/03/2026. This care plan included a goal showing Resident #18 will resume usual activities and minimize the risk of further incidents through next review date, initiated 07/15/2025, revised date 5/27/2026. This care plan included interventions that showed frequent rounding while in bed, date initiated 12/17/2025. Frequent rounding when resident is in the wheel chair in his room, Date initiated 02/03/2026, revised on 4/15/2026 and Medication review, date initiated 03/09/2026. On 04/15/2026 at 12:12 PM, an interview was conducted with Staff I, License Practical Nurse (LPN) /Minimum Data Set (MDS) coordinator. Staff I stated she started at the facility in mid-to-late September. She stated everyday she updates the care plans. A report is ran every day to see if there have been any changes to residents' orders, behaviors, or if a resident is placed on oxygen. From that information, she updates the care plan in the electronic medical record (EMR). Staff I stated the reports she runs also show whenever a resident has a fall. The Interdisciplinary Team (IDT) meets if a resident had a fall over night. They discussed the fall. Then the team would come up with an intervention for the resident's fall. Staff I stated the care plan would have an intervention for every fall a resident has had. Staff I stated she did not know why the IDT put frequent round when Resident #18 was in the wheelchair in his room for his fall on 2/2/2026 and they already had an intervention put in place on 12/17/2025 to frequently round when Resident #18 is in bed. Staff I stated she did not know why the IDT put to review Resident #18 medication for an intervention for his fall on 3/8/2026, when the facility already reviews his medications. Staff I stated, Maybe it was a specific medication they wanted to review, Staff I stated she was not sure about the medication because the record doesn't show which medications were reviewed. On 04/15/2026 at 1:58 PM, an interview was conducted with the Director of Nurses (DON). The DON stated Resident #18 had two different interventions to frequently round in his room because those were the intervention the facility used when she first started working at the facility. The DON stated her expectation was her staff should conduct frequent rounds every day as part of their assignment. The DON stated the interdisciplinary team had a meeting on 02/9/2026, and they discussed Resident #18. The intervention they put in place was that they made changes to his chair, but she did not know why that information was not updated on his care plan. The DON stated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #18 had a fall on 03/8/2026 and they discussed his anxiety medications, but she was not able to see what changes were made to his medication. The DON stated her expectation was when there is an IDT meeting, a progress note is documented in the electronic medical records to show what changes were made, and the care plan should be updated accurately. The DON stated when she reviewed Resident #18's medications, she did not see any information that showed Resident #18 medication was reviewed and adjusted after their fall meeting on 3/8/2026. Review of a policy titled, Fall Management Revision date, 07/29/2019 showed, overview, Residents are evaluated for fall risk. Patient centered interventions are initiated, based on resident risk. 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. Process: C. Post Fall Strategies 5. Update care plan and nurse aide Kardex (a nursing quick reference guide for patient information and care needs) with intervention(s) 8. Update plan of care with new interventions as appropriate Review of a policy titled, Plan of Care, Revision date, 09/25/2017 showed under 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: Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current intervention after the completion of each Omnibus Budget Reconciliation Act (OBRA) Minimum Data Set (MDS) assessment (except discharge assessment), and as needed.