STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105952	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Grand Oaks	3001 Palm Coast Parkway SE Palm Coast, FL 32137

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	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 resident and staff interviews, review of facility and resident records, and a review of the manufacturer's instructions for Resident #1's rolling walker, the facility failed to ensure that Resident #1 received adequate supervision and sufficient safeguards to prevent an avoidable accident. Staff failed to understand the proper use of the resident's rollator which resulted in Resident #1, one of seven residents reviewed for accidents, falling backwards and striking his head on the cement sidewalk. This failure resulted in a traumatic subarachnoid hemorrhage requiring three days of monitoring in the Intensive Care Unit (ICU) at an acute care hospital.On 04/06/2026 at approximately 10:35 AM while on a group nature walk/resident outing, Resident #1 was walking on the sidewalk using his four-wheeled walker (FWW)/rollator with oversight/assistance from the Social Services Director (SSD). Resident #1 became tired and sat down on the seat of his walker. The SSD began pushing him down the sidewalk toward the facility while he was sitting on the walker facing her. The wheels of the walker caught on a gap in the sidewalk, the walker stopped abruptly, and the resident fell backwards, striking the back of his head against the cement sidewalk. This resulted in a traumatic subarachnoid hemorrhage requiring hospitalization from 04/06/2026 through 04/09/2026 with monitoring in the intensive care unit due to the risk of neurological deterioration. The SSD had not been trained on resident safety regarding the use of resident mobility devices. The facility's therapy department and the Administrator stated non-clinical staff members were not provided any training on resident safety, yet these employees were escorting/supervising residents during facility outings.Immediate Jeopardy (IJ) at a scope and severity of J (isolated) was identified on 05/11/2025 at 1:25 PM.On 04/06/2026, Immediate Jeopardy began.On 05/13/2026 at 3:30 PM, the Administrator was notified of the IJ determination. An IJ template was provided, and Immediate Jeopardy was ongoing as of the survey exit on 05/13/2026.The findings include:A review of Resident #1's medical record revealed an admission date of 05/29/2024 with a transfer to an acute care hospital on [DATE] and a re-entry on 04/09/2026. His diagnoses included traumatic subarachnoid hemorrhage (bleeding between the brain and the tissues covering it, caused by a physical head injury such as a fall) without loss of consciousness, type II diabetes, dementia, muscle weakness, hypertension (high blood pressure), and generalized anxiety disorder. A review of the resident's active physician's orders revealed:-Acetaminophen (over-the-counter pain reliever for mild to moderate pain) Oral Tablet 325 mg (milligrams), two tabs every six hours as needed for pain/temp (temperature), start date: 04/10/2026-Assess for pain every shift, start date: 04/10/2026-Norvasc Oral Tablet 10 MG (Amlodipine Besylate - a prescription medication that widens and relaxes blood vessels, making it easier for the heart to pump blood). Give one tablet by mouth QD (daily) hold for HR <60 (heartrate of less than 60 beats per minute (BPM) related to hypertension, start date: 04/11/2026A review of the active care plan (revised 9/15/2025) revealed that the resident was at risk for falls related to gait/balance problems and general weakness. Interventions included anticipating and meeting the resident's needs. There were no care plans addressing mobility needs, assistance required from staff or mobility devices used. A review of the quarterly minimum data set (MDS) assessment with an (continued on next page)

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

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He smiled when greeted and stated he was unable to recall how long he had been living at the facility. He could not recall having had any falls or hospitalizations. When he was asked if he went out on walks to the park, he reported that he did not know and he could not remember.In an interview with the Director of Rehabilitation on 05/11/2026 at 4:42 PM, she reported that she had been employed by the facility for almost two years. She confirmed that the therapy department did not participate in or provide staff education or training, including new employee orientation or post-incident training. She further stated the therapy department provided no specific information to staff about resident safety, mobility or transfers. She confirmed that the therapy department was currently working with Resident #1 since his return to the facility after his fall incident on 04/06/2026 during a resident outing.In an interview with the Assistant Director of Nursing/Staff Educator on 05/12/2026 at 9:04 AM, she reported working in her current role for under two years. She said she was responsible for new employee/staff orientation, annual training and nursing competencies. She reported that all staff went through dementia training, elopement training, and bloodborne pathogens. The certified nursing assistants (CNAs) had their own competencies, and non-clinical staff such as the Social Services Department and Human Resources Department participated in training about hand hygiene, dawning and doffing PPE and infection control, and fall prevention that included keeping things within the residents' reach, keeping resident rooms clutter free, and cleaning up spills on the floor. Safe mobility techniques were discussed only with the clinical staff. She denied providing any training to staff (clinical or non-clinical) about mobility and safety during resident community outings prior to the recent incident involving Resident #1.In an interview with the Administrator in Training (AIT) on 05/12/2026 at 10:10 AM, he reported starting his AIT program at a different facility/location with the same company and then transferred to this facility with the current Administrator in December of 2025. He stated training he received during new employee orientation did not include fall prevention education. He stated he shadowed the activities department in the first facility he worked in and they trained him on resident transfers; however, this facility had not. He stated he could not recall what the procedures were for resident community outings; however, he did volunteer for both community outings, the nature walk (April 2026) and the picnic in the park (May 2026), where he was assigned his own resident to supervise while on each outing. He confirmed that no discussion took place prior to the outing, and no coordination of resident care needs took place. He confirmed that he witnessed Resident #1's fall on 04/06/2026. It was toward the end of the nature walk when he saw the SSD unsafely pushing Resident #1 on his walker. The AIT was approximately 20 feet away and noticed they were slowing down, so he waited but said nothing. When he reached the facility on the sidewalk, he saw the SSD hit a gap/bump in the sidewalk and Resident #1 started falling backwards. The SSD tried to break his fall, but it happened too fast and the resident fell to the ground. The Administrator came to make sure Resident #1 was okay and saw that his head was on the ground. Nursing was contacted, they came and assessed Resident #1 prior to getting him up and asked him questions. He responded well and was ready to get up and walk back to the building, though he had a bruise on the top of his head. The AIT confirmed that no training was offered to staff regarding safety during community outings and stated he felt better coordination for the activity should have occurred. The length of the walk was too long; someone should have done some recon (reconnaissance - gathering of information about the target area prior to the event) of the walk with a plan discussed (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	prior to the outing, but that didn't happen. No one walked the route to see what the walk would even be like. On 5/12/2026 at 11:04 AM, an interview was conducted with the Business Office Manager who stated she had been in her position a little over a year. Upon hire, she received abuse and neglect training but denied receiving any fall/accident prevention training or safe mobility/transfer assistance training in her current role. She said she had volunteered when there was a resident activity or event. She said she was asked at the last minute to assist with the nature walk in April because there weren't enough staff for the event. She did not know the resident she was assigned to supervise during the walk; all of the residents going on the activity were gathered in the front foyer of the facility and she was asked to just pick someone, so she did. The walk was approximately 15-20 minutes long and almost one full mile. They completed a scavenger hunt, they stopped at the picnic tables, went over the scavenger hunt paper, then turned back toward the facility. She reported not being familiar with her assigned resident's specific care needs or any information about their mobility care needs or assistance required. She said she did not witness the incident with Resident #1 and his walker, but if she saw someone getting pushed on a walker that way she would say something because it's not safe and the incident involving Resident #1 could have been avoided if the walker was being used safely and appropriately. On 05/12/2026 at 12:12 PM, an interview was conducted with the facility's Administrator, who reported that he attended the nature walk as a volunteer on 04/06/2026. It was the first outing since his arrival at the facility in November of 2025. Extra staff were needed for the outing at the last minute, so he was assigned to supervise a resident while on the walk. He did not witness the incident involving Resident #1, but he did assist after the fall. He reported that there was no facility policy for them to follow for external resident outings, so this was a lesson learned and little changes were made but nothing in writing. This would be discussed in the next QAPI (quality assurance and performance improvement) meeting. His said his expectation for staff leaving the facility with residents was that they were properly supervised with safety measures maintained throughout the event. He said this was not in place prior to the 04/06/2026 event with Resident #1, so going forward, once it was determined that residents needed special or different interventions or care, staff would be educated about the best way to manage their care/safety while out on the event; wheelchairs would also be brought along. This was the first event, and we don't have a strong policy on this. He further reported that all staff attending and assisting during the nature walk would mostly be department heads/management. Some would be clinical, and he was okay with that. He confirmed that emergency Ad-Hoc meetings were held on 04/16/2026 and 4/20/2026 and the Medical Director was not in attendance, but he did brief them on the incident. He stated the Medical Director did not state one could not push a resident on a walker, only that the resident could only be pushed in one direction and that was with the resident facing staff (sitting backwards). Moving forward, wheelchairs would be used. He stated staff were not prepared and no one walked the nature walk prior to the scheduled outing to determine the length and time it would take the residents to make the round trip or the supplies/equipment needed. On 05/12/2026 at 1:13 PM, a telephone interview was conducted with the Medical Director. He confirmed having been made aware of the 04/06/2026 incident involving Resident #1 immediately. He said he was told that the resident fell backwards from a rolling walker and hit his head, so we sent him to the hospital for further evaluation. He reported attending the facility's QAPI meeting but couldn't recall the date. He further stated that if he did not attend in person, he joined via telephone. When he was asked if having a resident pushed while seated on a four-wheeled walker was considered safe practice, he replied, If a patient needs to sit down in the facility to rest, but outside, I don't think it's safe to do that. Small wheels would hit every nook and cranny, and if on a sidewalk, the walker would go right over.In an interview with the Director of Nursing (DON) on 05/12/2026 at 2:38 PM, she said she recalled having been notified that Resident #1 had fallen. She said she responded immediately with a team and assessed him, then the Unit Manager called to inform the family, and EMS (emergency medical services) was contacted for a transfer to the hospital for a CT scan because he hit his head. She (continued on next page)

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