

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105996	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Aviata at Spring Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 12170 Cortez Blvd Brooksville, FL 34613	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51024</p> <p>Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 3 of 7 residents reviewed, Residents #28, #30, and #105.</p> <p>Findings include:</p> <p>1) Review of Resident #105's progress note dated 1/30/2025 at 7:53 AM read, EMS [Emergency Medical Service] called for emergent transfer to local ER [emergency room] for evaluation and treatment.</p> <p>Review of Discharge Return Anticipated MDS assessment dated [DATE] showed the resident was discharged to home/community under Section A- 2105: Discharge Status.</p> <p>During an interview on 4/23/2025 at 9:30 AM, Staff C, MDS Registered Nurse (RN), and Staff D, RN, stated, There is an MDS discrepancy since section A reads that resident is coded that resident discharged to home on 1/30/2025, however, the progress notes show that the APRN [Advanced Practice Registered Nurse] sent [Resident #105's name] to hospital on 1/30/2025.</p> <p>During an interview on 4/24/2025 at 9:16 AM, the Director of Nursing confirmed there was an MDS discrepancy on Section A- discharge status.</p> <p>51447</p> <p>2) Review of Resident #28's physician order dated 3/20/2025 read, Sertraline HCl Oral Tablet 25 MG (Sertraline HCl), Give 50 mg by mouth one time a day for depression.</p> <p>Review of Resident #28's quarterly MDS dated [DATE] showed the resident was not receiving antidepressant medications under Section N- Medications.</p> <p>During an interview on 4/24/2025 at 1:25 PM, Staff C, MDS RN, confirmed that Section N of Resident #28's MDS is incorrect.</p> <p>3) Review of Resident #30's physician order dated 3/5/2025 read, Atenolol Oral Tablet 50 MG (Atenolol), Give 1 tablet by mouth every 12 hours for HTN hold, for sbp [systolic blood pressure] less than 100 or pulse less than 60.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #30's quarterly MDS dated [DATE] did not show hypertension indicated as a diagnosis under Section I- Active Diagnoses.</p> <p>During an interview on 4/24/2025 at 1:25 PM, Staff C, MDS RN, confirmed that Section I of Resident #30's MDS is incorrect.</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523</p> <p>Based on record review and interview, the facility failed to ensure an accurate Preadmission Screening and Resident Review (PASRR) was completed for 3 of 5 residents reviewed for mood and behavior, Residents #28, #30, and #256.</p> <p>Findings include:</p> <p>1) Review of Resident #256's admission record showed the resident was admitted on [DATE] with the diagnoses including schizoaffective disorder and major depressive disorder with onset dates of 4/9/2025.</p> <p>Review of Resident #256's PASRR dated 3/25/2025 showed no mental illness documented.</p> <p>Review of Resident #256's physician order dated 4/10/2025 read, Sertraline HCl Oral Tablet 100 MG [milligrams] (Sertraline HCl), Give 1 tablet by mouth one time a day for depression.</p> <p>Review of Resident #256's physician order date 4/17/2025 read, Quetiapine Fumarate Oral Tablet 50 MG (Quetiapine Fumarate), Give 50 mg by mouth at bedtime related to schizoaffective disorder, depressive type . home med [medication], patient declines GDR [gradual dose reduction].</p> <p>Review of Resident #256's psych admission note dated 4/15/2025 read, Chief Complaint: I'm ready to go home. History of Present Illness: This patient is a [AGE] year-old female who was admitted to this facility on 4/9/2025 with a diagnosis of traumatic subdural hemorrhage without loss of consciousness. Today's visit: The patient has a history of depression, schizoaffective disorder (depressive type with disorganized thinking and hallucinations), and prior opioid and nicotine dependence. She reports no anxiety with her current drug regimen but admits to depression related to adjustment, due to being away from her family and home.</p> <p>During an interview on 4/24/2025 at 8:43 AM, the Director of Nursing (DON) stated, Admission will ask for the screening, but they do not review them. I review them after resident is admitted in about 7 days. [Resident #256's name] screening needs to be revised to include the schizoaffective and major depressive diagnosis.</p> <p>Review of the facility policy and procedure titled Preadmission Screening and Resident Review (PASSR) with the last review date of 1/20/2025 read, Policy: The center will assure that all Serious Mentally Ill (SMI) and Intellectually Disabled (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 screening, 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.</p> <p>51447</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2) Review of Resident #28's admission record showed the resident was most recently admitted on [DATE] with diagnoses including major depressive disorder with onset date of 12/26/2024.</p> <p>Review of Resident #28's PASRR dated 11/27/2024 showed no mental illness documented.</p> <p>Review of Resident #28's physician order dated 3/20/2025 read, Sertraline HCl Oral Tablet 25 MG (Sertraline HCl), Give 50 mg by mouth one time a day for depression.</p> <p>Review of psychiatric progress note dated 3/20/2025 read, Medical Necessity/ Reason for Today's Visit . Follow up for Medication and Behavior management and lab review . Follow-up after recent medication change.</p> <p>During an interview on 4/24/2025 at 9:57 AM, the DON confirmed that the PASSR was not accurate for Resident #28.</p> <p>3) Review of Resident #30's admission record showed the resident was most recently admitted on [DATE] with the diagnoses including major depressive disorder and generalized anxiety disorder with onset dates of 1/30/2025.</p> <p>Review of Resident #30's PASRR dated 2/16/2025 showed no mental illness documented.</p> <p>Review of Resident #30's physician order dated 2/17/2025 read, Trazodone HCl Oral Tablet 50 MG (Trazodone HCl), Give 1 tablet by mouth at bedtime related to major depressive disorder.</p> <p>Review of Resident #30's physician order dated 3/14/2025 read, Paroxetine HCl Oral Tablet 20 MG (Paroxetine HCl), Give 1 tablet by mouth one time a day related to panic disorder (episodic paroxysmal anxiety), major depressive disorder.</p> <p>During an interview on 4/24/2025 at 9:57 AM, the DON confirmed that the PASSR was not accurate for Resident #30.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45576</p> <p>Based on record review and interview, the facility failed to develop and implement a comprehensive care plan for 1 of 4 residents reviewed for oxygen therapy, Resident #37.</p> <p>Findings include:</p> <p>Review of Resident #37's admission record showed the resident was initially admitted on [DATE] with the diagnoses including chronic obstructive pulmonary disease (COPD), heart failure, presence of cardiac pacemaker, syncope and collapse, anemia, atherosclerotic heart disease of native coronary artery, chest pain, and peripheral vascular disease.</p> <p>During an observation on 4/22/2025 at 8:11 AM, Resident #37 was sitting on the side of the bed with an oxygen concentrator set at 2 liters and the oxygen tubing was lying on the ground.</p> <p>During an interview on 4/22/2025 at 8:11 AM, Resident #37 stated, I removed the oxygen, and I put it on whenever I need to.</p> <p>Review of Resident #37's physician order dated 1/27/2025 read, Oxygen As Needed (PRN) 2 L [liters] via nasal cannula.</p> <p>Review of Resident #37's physician order dated 7/21/2024 read, May self-administer medications.</p> <p>Review of Resident #37's care plan dated 1/31/2025 showed no focus for oxygen administration and self-administration of medications.</p> <p>Review of Resident #37's weights and vitals summary from January 1, 2025 through April 22, 2025 showed the resident received oxygen via nasal cannula on 1/12/2025, 1/13/2025, 1/16/2025, 1/18/2025, 1/23/2025, 1/27/2025, 2/1/2025, 2/6/2025, 2/9/2025, 2/10/2025, 2/13/2025, 3/26/2025, 3/27/2025 and 4/1/2025.</p> <p>During an interview on 4/22/2025 at 3:22 PM, Staff C, Minimum Data Set (MDS) Registered Nurse (RN), confirmed that there was no care plan written for oxygen therapy.</p> <p>During an interview on 4/23/2025 at 9:46 AM, the Director of Nursing (DON) confirmed that Resident #37 did not have a care plan for oxygen or for self-administration of medications, and the resident should be care planned for both.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy and procedure titled Plans of Care with the last review date of 1/20/2025 read, 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 interventions after the completion of each OBRA [Omnibus Budget Reconciliation Act] MDS assessment (except discharge assessments, and as needed. 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.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>46523</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received appropriate wound care for 2 of 6 residents reviewed for skin and wound care, Residents #65 and #406.</p> <p>Findings include:</p> <p>1) During an observation on 4/21/2025 at 9:16 AM, Resident #406 was lying in bed. There was a gauze island bordered dressing on the resident's left forearm, which was dated 4/20/2025 (Photographic evidence obtained).</p> <p>During an observation on 4/22/2025 at 9:30 AM, Resident #406 was lying supine in bed, wearing blue foam heel protectors. There was a gauze bordered dressing on the resident's left forearm, which was dated 4/20/2025.</p> <p>During an observation on 4/22/2025 at 12:50 PM, Resident #406 was sitting in his wheelchair in his room. There was a foam bordered dressing on the resident's left forearm, which was dated 4/22/2025 with no initials.</p> <p>Review of Resident #406's physician orders did not show an order for wound care for the resident's left forearm.</p> <p>During an interview on 4/23/2025 at 10:17 AM, Staff F, Licensed Practical Nurse (LPN), stated, [Resident 406's name] has orders for wound care to right lower extremity, but I don't see any for his left forearm. I don't see any change of condition notes.</p> <p>During an interview on 4/23/2025 at 10:47 AM, the Director of Nursing (DON) stated, [Resident #406's name] does not have orders for wound care to the left forearm. The staff are not supposed to do wound care without having a wound care order. They are supposed to initial and date all dressings.</p> <p>2) During an observation on 4/21/2025 at 11:11 AM, Resident #65 was sitting in her wheelchair in her room. There was a white gauze wrapped dressing on the resident's right arm, which had no date or initials (Photographic evidence obtained).</p> <p>During an observation on 4/22/2025 at 8:35 AM, Resident #65 was lying in her bed. There was a white gauze wrapped dressing on the resident's right arm, which had no date or initials.</p> <p>During an observation on 4/23/2025 at 8:30 AM, Resident #65 was sitting in her wheelchair in her room. There was a white gauze wrapped dressing on the resident's right arm, which had no date or initials.</p> <p>Review of Resident #65's physician orders did not show an order for dressing changes for the resident's right arm.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/23/2025 at 10:37 AM, Staff G, Registered Nurse (RN), stated, Wound care dressings should be dated. There should be orders for wound care.</p> <p>During an interview on 4/23/2025 at 10:50 AM, the DON stated, Dressing should be dated. [Resident #65's name] has orders for skin prep, but I do not see wound care orders to wrap with a gauze.</p> <p>Review of the facility policy and procedures titled Dressing, Dry/Clean with the last review date of 1/20/2025 read, Purpose: The purpose of this procedure is to provide guidelines for the application of dry, clean dressings. Preparation: 1. Verify that there is a physician's order for this procedure . Steps in the procedure . 17. Apply the ordered dressing and secure with tape or bordered dressing per order. (Note: Use non-allergenic tape as indicated.) Label with date and initials to top of dressing.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>52507</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents received appropriate oxygen therapy for 2 of 4 residents reviewed for respiratory services, Residents #406 and #407.</p> <p>Findings include:</p> <p>1) During an observation on 4/21/2025 at 11:38 AM, Resident #406 was lying in bed, receiving oxygen via nasal cannula (NC) at 2 liters per minute (L/min).</p> <p>During an observation on 4/22/2025 at 9:30 AM, Resident #406 was lying in bed, wearing receiving oxygen via NC at 2L/min.</p> <p>Review of Resident #406's physician order dated 4/17/2025 read, Respiratory: Oxygen For comfort.</p> <p>During an interview on 4/23/2025 at 12:50 PM, the Director of Nursing (DON) stated, We should have added 2 liters on the order. The oxygen was ordered per patient request. He wanted to be on oxygen.</p> <p>During an interview on 4/23/2025 at 10:17 AM, Staff F, Licensed Practical Nurse (LPN), stated, I do expect oxygen orders to have a flow rate, especially if they have COPD [Chronic Obstructive Pulmonary Disease], so that we don't hyper oxygenate them.</p> <p>2) During an observation on 4/21/2025 at 10:10 AM, Resident #407 was lying in bed, receiving oxygen via NC with tubing attached to an oxygen concentrator, which was set to 2 liters per minute.</p> <p>During an observation on 4/22/2025 at 10:30 AM, Resident #407 was lying in bed, receiving oxygen via nasal at 2 liters per minute.</p> <p>Review of Resident #407's physician orders showed no orders for administration of oxygen.</p> <p>During an interview on 4/22/2025 at 12:50 PM, the DON stated, I only see an order for O2 [oxygen] tubing changes. She [Resident #407] needs an order for O2.</p> <p>During an interview on 4/23/2025 at 10:40 AM, Staff G, Registered Nurse (RN), stated, There should be orders in the system when a patient is on oxygen. Usually for comfort care, we do 2 liters.</p> <p>Review of the facility policy and procedure titled Oxygen Therapy with the last review date of 1/20/2025 read, Policy: Oxygen therapy is the administration of a FiO2 [fraction of inspired oxygen] greater than 21% by means of various administration devices to: raise the resident's PaO2 [partial pressure of oxygen] to an acceptable baseline using the lowest FiO2, to treat hypoxemia, to decrease work of breathing, to reverse and prevent tissue hypoxia, and/or to decrease myocardial work. Procedure: Physician's order for oxygen therapy shall include: Administration modality, FiO2 or liter flow, continuous or PRN [as needed], PRN orders must include specific guidelines as to when the resident is to use oxygen.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>46523</p> <p>Based on record review and interview, the facility failed to ensure residents were assessed before and after dialysis treatments for 1 of 1 resident receiving dialysis services, Resident #39.</p> <p>Findings include:</p> <p>Review of Resident #39 Hemodialysis Communication Record dated 4/10/2025 showed no pre and post dialysis vital signs or observations documented.</p> <p>Review of Resident #39's Hemodialysis Communication Record dated 4/12/2025 showed no pre and post dialysis vital signs or observations documented.</p> <p>Review of Resident #39's Hemodialysis Communication Record dated 4/22/2025 showed no pre and post dialysis vital signs or observations documented.</p> <p>Review of Resident #39' records showed no hemodialysis communication documentation for 3/8/2025, 3/11/2025, 3/13/2025, 3/20/2025, 3/22/2025, 3/25/2025, 3/27/2025, 3/29/2025.</p> <p>Review of Resident #39's physician order dated 3/6/2025 read, Hemodialysis Tuesday, Thursday, Saturday, [name, address and phone number of local dialysis center and transportation company information] every day shift every Tue [Tuesday], Thu [Thursday], Sat [Saturday] for ESRD [End Stage Renal Disease]/Hemodialysis send a Lunch.</p> <p>During an interview on 4/23/2025 at 3:42 PM, the Director of Nursing (DON) stated, For [Resident #39's name], I don't have any other communication forms for dialysis. I do not know if the nurses know to do the pre and post dialysis form. I have not educated them on it.</p> <p>During an interview on 4/23/2025 at 3:44 PM, Staff H, Licensed Practical Nurse (LPN), stated, Residents that go to dialysis have a binder, and in the form, we have to record the vitals, medications and assessment. When the residents come back, we have to assess them again and fill out the bottom portion of the form.</p> <p>Review of the facility policy and procedure titled Coordination of Hemodialysis Services with the last review date of 1/20/2025 read, Policy: Residents requiring an outside ESRD facility will have services coordinated by the facility. There will be communication between the facility and the ESRD facility regarding the resident. The facility will establish a Dialysis Agreement/ Arrangement if there are any residents requiring Dialysis Services. The agreement shall include how the residents [Sic.] care is to be managed. Procedure: 1. The Dialysis Communication form will be initiated by the facility for any resident going to an ESRD center for hemodialysis . 5 Nursing will complete the post dialysis information on Dialysis Communication form and file the completed form in the Resident's Clinical Record.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>45576</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were secured in one of two halls (400 Hall).</p> <p>Findings include:</p> <p>1) During an observation on 4/21/2025 at 11:25 AM, there was one bottle of antifungal powder (Miconazole Nitrate 2%) on the bedside table in Resident #3's room (Photographic evidence obtained).</p> <p>During an interview on 4/21/2025 at 11:25 AM, Resident #3 stated, The CNA [Certified Nursing Assistant] will put the fungal powder on my arms and legs once a day.</p> <p>During an observation on 4/22/2025 at 8:05 AM, there was one bottle of antifungal powder (Miconazole Nitrate 2%) on the bedside table in Resident #3's room.</p> <p>2) During an observation on 4/21/2025 at 10:00 AM, there was one bottle of Equate medicated body powder, active ingredient menthol 0.15%, on the bedside table in Resident #37's room (Photographic evidence obtained).</p> <p>During an observation on 4/22/2025 at 8:11 AM, there was one bottle of Equate medicated body powder, active ingredient menthol 0.15%, on the bedside table in Resident #37's room.</p> <p>During an interview on 4/22/2025 at 8:11 AM, Resident #37 stated, I put the powder on my groin at least daily and sometimes even more when I get sweaty.</p> <p>During an interview on 4/22/2025 at 8:45 AM, Staff A, CNA, confirmed the medication was unsecured at the bedside and stated, I would tell the nurse, but no medication can be at the bedside. I do not apply any medications to the residents.</p> <p>During an interview on 4/22/2025 at 8:57 AM, Staff B, Licensed practical Nurse (LPN), stated, Medication is not allowed at the bedside. If they have been evaluated for self-administration, the medication can remain at the bedside, but the medication still needs to be locked in the drawer to make sure that the medication is secured.</p> <p>During an interview on 4/22/2025 at 9:11 AM, the Assistant Director of Nursing stated, Medications are not allowed at the bedside unsecured. If they have been evaluated for self-administration, the medication can remain at the bedside, but the medication still needs to be locked in the drawer to make sure that they are secured.</p> <p>During an interview of 4/23/2025 at 9:46 AM, the Director of Nursing (DON) stated, The nystatin powders should not have been in the room. No medication is allowed to be stored in the room unless the resident is screened for self-administration and then the medications can be stored in the room but locked up.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Aviata at Spring Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 12170 Cortez Blvd Brooksville, FL 34613	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy and procedure titled Medication Storage with the last review date of 1/20/2025 read, Policy: Medications will be stored in a manner that maintains the integrity of the product and ensures the safety of the residents and is in accordance with FL Department of Health Guidelines. Procedure: A. With the exception of Emergency Drug Kits, all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined by facility policy.</p> <p>46523</p> <p>3) During an observation on 4/21/2025 at 10:09 AM, Resident #407 was lying in bed, wearing a gown. There was a Dextrose 5% intravenous (IV) fluid bag running. Neither IV bag nor tubing was dated.</p> <p>During an observation on 4/22/2025 at 12:50 PM, Resident #407 was lying in bed, wearing a gown. There was a Dextrose 5% intravenous (IV) fluid bag running. Neither IV bag nor tubing was dated.</p> <p>During an interview on 4/23/2025 at 10:40 AM, Staff G, Registered Nurse (RN), stated, [Resident #407's name] fluid bag should be dated. I am not sure about dating the tubing because it gets discarded.</p> <p>During an interview on 4/23/2025 at 11:00 AM, the Director of Nursing (DON) stated, Normally IV bag and tubing should be dated, initialed and timed.</p> <p>Review of the facility policy and procedure titled Intravenous Administration of Fluids and Electrolytes with the last review date of 1/20/2025 read, Policy: Staff will be knowledgeable regarding safe and aseptic administration of intravenous fluids and electrolytes for hydration. Procedure . 8. When infusion is complete . For continuous therapy: a. [NAME] solution container with label that states when bag started and approximate time of completion. b. Never write directly on the bag with ink or marker; always use a label or tape.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>46523</p> <p>Based on observation, interview and record review, the facility failed to maintain complete and accurate medical records for 4 of 7 residents reviewed for medication administration, Residents #37, #39, #256, and #407.</p> <p>Findings include:</p> <p>1) Review of Resident #256's physician order dated 4/14/2025 read, Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML [milliliter] (Insulin Lispro), Inject as per sliding scale: if 120-150=1; 151-200=2 units; 201-250= 4 units; 251-300= 6 units, subcutaneously before meals and at bedtime related to type 2 diabetes mellitus with hypoglycemia with coma.</p> <p>Review of Resident #256's Medication Administration Record (MAR) for April 2025 for administration of Insulin Lispro using a sliding scale showed blood sugar level of 123 and code 12 (Insulin not required) on 4/15/2025 at 9:00 PM, blood sugar level of 387 and code 1 [Held per parameters] on 4/18/2025 at 9:00 PM, blood sugar level of 90 and code 12 on 4/19/2025 at 4:00 PM, blood sugar level of 480 and code 11 on 4/21/2025 at 9:00 PM, and blood sugar level of 322 and code 11 on 4/22/2025 at 6:00 AM.</p> <p>Review of Resident #256's physician order dated 4/15/2025 read, Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro), Inject 5 unit subcutaneously with meals for DM [Diabetes Mellitus].</p> <p>Review of Resident #256's MAR for April 2025 for administration of Insulin Lispro 5 units showed blood sugar level of 90 and code 12 on 4/19/2025 at 4:30 PM, blood sugar documented as NA (Not Applicable) on 4/20/2025 at 6:30 AM and at 4:30 PM, and on 4/22/2025 at 6:30 AM.</p> <p>During an interview on 4/22/2025 at 1:49 PM, the Director of Nursing (DON) stated, I spoke to [Staff I, Licensed Practical Nurse (LPN)'s name] and she stated she gave [Resident #256's name] insulin. She does not know why it was not documented accurately.</p> <p>During an interview on 4/23/2025 at 8:15 AM, the DON stated, I spoke to [Staff N, LPN's name] and he stated he documented NA [for Resident #256's blood sugar level] because he had documented the blood sugar previously. I expect the staff to document the blood sugar every time it is required on the medication administration record even if it is multiple times.</p> <p>During an interview on 4/23/2025 at 8:56 AM, Staff K, LPN, stated, [Resident #256's name] felt uncomfortable with her blood sugar and felt more comfortable without insulin coverage and I consulted with the physician. I did not document the conversation with the physician.</p> <p>During an interview on 4/23/2025 at 9:42 PM, Medical Doctor #1 stated, [Resident #256's name] has a sliding scale in addition to 5-unit standing order. The staff contact me and notify me if they will be holding the medication when it is out of parameters.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2) Review of Resident #407's physician order dated 4/9/2025 read, Insulin Glargine Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine), Inject 40 unit subcutaneously two times a day for DM.</p> <p>Review of Resident #407's MAR for April 2025 for administration of Insulin Glargine 40 units showed no entry documented on 4/16/2025 at 6:00 AM, code 12 on 4/17/2025 at 6:00 AM, and code 11 on 4/20/2025 at 6:00 AM.</p> <p>Review of Resident #407's physician order dated 4/9/2025 read, Novolin R FlexPen Injection Solution Pen-Injector 100 unit/ML (Insulin Regular (Human)), Inject as per sliding scale: if 151-200=1; 201-250= 2 unit; 251-300= 3 unit, subcutaneously before meals and at bedtime for DM.</p> <p>Review of Resident #407's MAR for April 2025 for administration of Novolin R Flex Pen showed no entry documented on 4/16/2025 at 6:00 AM.</p> <p>Review of Resident #407's progress notes for April 2025 did not document notification to the provider regarding blood sugar or insulin coverage.</p> <p>During an interview on 4/23/2025 at 8:15 AM, the DON stated, I spoke to [Staff I, LPN's name] and she stated [Resident #407's name] blood sugar was low, and she held the long-acting insulin, but did not recall if she contacted the provider. She stated normally she will contact the provider regarding holding any medication. Staff are expected to call the provider and get new orders or document the communication to the provider.</p> <p>During an interview on 4/23/2025 at 10:05 AM, Staff J, LPN, stated, [Resident #407's name] Long acting was given, and the short acting was held due to parameters. I do not know why it did not show in the system.</p> <p>During an interview on 4/23/2025 at 9:42 PM, Medical Doctor #1 stated, We follow [Resident #407's name] very closely regarding her diabetes. Nurses normally contact me if it is not by phone, it is in person when I am in the facility. The staff will call me if they are holding her insulin. She [Resident #407] sometimes runs pretty low.</p> <p>3) Review of Resident #39's physician order dated 3/5/2025 read, Insulin Aspart Subcutaneous Solution Pen-Injector 100 UNIT/ML (Insulin Aspart), Inject as per sliding scale: if 0-150=0; 151-200=2; 201-250=4; 251-300=6; 301-350=8; 351-400=10; 401 + =10 give 10 units and call MD [Medical Doctor] for further instructions, subcutaneously before meals for DM.</p> <p>Review of Resident #39's MAR for April 2025 for administration of Insulin Aspart showed blood sugar levels of 540 on 4/8/2025 at 4:30 PM, 545 on 4/15/2025 at 11:30 AM, 424 on 4/16/2025 at 11:30 AM and 431 at 4:30 PM, 497 on 4/19/2025 at 11:30 AM and 411 at 4:30 PM, and 437 on 4/20/2025 at 11:30 AM.</p> <p>Review of Resident #39's progress notes for April 2025 did not show notifications to the provider regarding blood sugar levels or insulin coverage.</p> <p>Review of Resident #39's physician order dated 3/5/2025 read, Insulin Aspart Flex Pen Subcutaneous Solution Pen Injector 100 UNIT/ML (Insulin Aspart), Inject 5 unit subcutaneously before meals for diabetes mellitus.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #39's MAR for April 2025 for administration of Insulin Aspart 5 units showed code 12 on 4/11/2025 at 6:30 AM, code 11 on 4/20/2025 at 6:30 AM, and code 12 on 4/21/2025 at 6:30 AM.</p> <p>Review of Resident #39's physician order dated 3/10/2025 read, Insulin Glargine Subcutaneous Solution Pen Injector 100 unit/ML (Insulin Glargine), Inject 15 units subcutaneously two times a day for DM.</p> <p>Review of Resident #39's MAR for April 2025 for administration of Insulin Glargine 15 units showed code 12 on 4/11/2025 at 6:00 AM.</p> <p>During an interview on 4/22/2025 at 3:49 PM, the DON stated, I spoke to [Staff B, LPN's name], who stated that she contacted [Medical Doctor #2's name] about [Resident #39's name] blood glucose being over 400 on 4/8/25, and [Medical Doctor #2's name] did not give any new orders at that time. [Staff B's name] stated that typically she would document the notification of the provider in the progress notes, and must have forgotten to document.</p> <p>During an interview on 4/22/2025 at 3:50 PM, the DON stated, I spoke to [Staff I, LPN's name], who stated that she spoke with [Medical Doctor #3' name] regarding [Resident #39's name] blood sugar being over 400 on 4/15, and 4/16 that he was notified, and there were no new orders.</p> <p>During an interview on 4/22/2025 at 3:51 PM, the DON stated, I spoke with [Staff L, LPN's name], who stated that a new order for insulin was added on 4/20 at 17:50 [5:50 PM] after reviewing 4/19 and 4/20 glucose results with MD.</p> <p>During an interview on 4/23/2025 at 9:00 AM, Medical Doctor #3 stated, The nurses call the concierge line and they have access to secured text line and frequently text any concerns to me. Communication from the staff has been good. I have thousands of patients and cannot remember if I was called about that specific patient on that day. Normally the staff call. I do expect nurses to call me if they are ever uncomfortable or have concerns about a patient.</p> <p>During an interview on 4/23/2025 at 9:14 AM, Staff M, LPN, stated, Saturday night we tried and sent a text message. I might have contacted the provider. I am not sure. Usually when I hold the insulin, I normally will call the doctor and let him know.</p> <p>45576</p> <p>4) Review of Resident #37's physician order dated 3/28/2025 read, Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine), Inject 25 unit subcutaneously at bedtime for DM, HOLD if BGM [Blood Glucose Monitoring] Less than 120, AND Inject 15 unit subcutaneously in the morning for DM2 hold for BG less than 100.</p> <p>Review of Resident #37's MAR for April 2025 showed blood sugar level of 94 on 4/8/2025 with 15 units of Insulin Glargine administered.</p> <p>During an interview on 4/23/2025 at 9:40 AM, Staff E, Registered Nurse (RN), stated, I reviewed the chart, and I had documented the blood sugar of 94 twice in error. I documented that I gave the insulin. I did not give the insulin in the AM [morning time] on 4/8/25.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/23/2025 at 3:28 PM, the Assistant Director of Nursing stated, If a medication is not given, then an explanation should be placed on why the medication was held. Physician orders are to be followed and if an error occurs in the chart. The error needs to be corrected.</p> <p>Review of the facility policy and procedure titled Medication-Oral Administration of with the last review date of 1/20/2025 read, Procedure . Review physician order . Review the MAR or EMAR [electronic Medication Administration Record] should there be any uncertainties verify the MAR or EMAR with the Physician's Order Sheet (POS) and seek clarification as indicated . Document the administration and acceptance or decline of all medications administered. This may include . b. When documenting in the EMAR, the nurse will document immediately prior to administration and or immediately post administration based on preferred individual professional practice of the nurse. Should the resident decline or be unable to accept the medication this will need to be documented following standard protocol.</p> <p>Review of the facility policy and procedure titled Insulin Administration-Injection Pens with the last review date of 1/20/2025 read Procedure . Document in medical record.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>52507</p> <p>Based on observation, record review, and interview, the facility failed to establish antibiotic stewardship program to monitor antibiotic use for 1 of 3 residents reviewed for antibiotic use, Resident #406.</p> <p>Findings include:</p> <p>Review of Resident #406's physician order dated 4/17/2025 read, Erythromycin Ophthalmic Ointment 5 MG (milligram)/GM (gram), Instill 1 application in left eye three times a day for eye infection . Order Status: Active. Start Date: 04/17/2025. End date: [Blank].</p> <p>During an observation on 4/23/2025 at 8:13 AM, Resident #406 was sitting up in bed, eating breakfast. Resident #406's left eye was not red or drooping, and no drainage was visible.</p> <p>During an interview on 4/23/2025 at 10:17 AM, Staff F, Licensed Practical Nurse (LPN), stated, I think the Erythromycin antibiotic ointment is ordered continuously for him and was something he was using at home for drooping, draining left eye. It has an indefinite end date.</p> <p>During an interview on 4/23/2025 at 10:47 AM, the DON (Director of Nursing) stated, Antibiotics normally have a stop date. We are waiting for the provider to see [Resident #406's name] before we put in a stop date for his erythromycin ointment. When I saw his left eye on Monday, it still had a lot of drainage.</p> <p>During an interview on 4/23/2025 at 3:05 PM, the Infection Preventionist stated, Usually antibiotic orders have an end date. Everything should have an end date. When [Resident #406's name] came in his eye showed signs of an eye infection and now he [Resident #406] started to clear up and is doing better. [Resident #406's name] came in with that order.</p> <p>Review of the facility policy and procedure titled Antibiotic Stewardship -Orders for Antibiotics with the last review date of 01/20/2025 read, Policy Statement: Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program and in conjunction with the facility's general policy for Medication Utilization and Prescribing. Policy Interpretation and Implementation . 2. If an antibiotic is indicated, prescribers will provide complete antibiotic orders including the following elements . d. duration of treatment: (1) start and stop date or (2) number of days of therapy.</p>