

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2026
NAME OF PROVIDER OR SUPPLIER Aviata at Lake Mary		STREET ADDRESS, CITY, STATE, ZIP CODE 710 North Sun Drive Lake Mary, FL 32746	
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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to maintain exterior waste areas in sanitary condition for 1 of 1 waste handling locations reviewed. Unsanitary waste conditions may attract pests and increase risk for food contamination. Findings: On 4/20/26 at 8:30 AM, during a tour of the exterior dumpster area with the Certified Dietary Manager (CDM), widespread litter and food related debris was strewn around the receptacle. Sugar packets, salt packets, powdered creamer packets, paper towels, used disposable gloves, graham crackers, and condiment packets were scattered across the concrete surfaces inside the enclosure and throughout the surrounding ground. Debris extended 15-20 feet beyond the enclosure and over the fence line into the grass and the gravel. Some of the trash on the ground was weathered, indicating the debris had accumulated over time rather than resulting from a single disposal event. The CDM confirmed the findings. A few minutes later, behind the building, thirteen cigarette butts were on the ground near the shut off valve and grease trap. Grease staining and residue were visible around the grease trap access point. There was no No Smoking signage posted in the area despite the presence of cigarette waste. On 4/20/26 at 8:35 AM, the (CDM) reported he had no knowledge of staff who smoked and stated the building operated as a nonsmoking facility. He explained dietary staff held the responsibility for keeping waste areas clean outside and were expected to remove debris during each shift. On 4/20/26 at 1:55 PM, the CDM acknowledged trash around the dumpster and cigarettes around the shut off valve weren't acceptable per facility expectations. He stated staff must remove debris daily, monitor for food waste accumulation, and maintain waste areas free from trash that could attract pests or create odors. CDM explained his expectation was staff should immediately clean the area.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, and interview, the facility failed to ensure food was stored and handled in a sanitary manner for 2 of 2 kitchen areas reviewed (dry storage and tray service area). Improper storage of bulk food items and improper employee hygiene practices placed residents at risk for contamination and foodborne illness. Findings: On 4/20/26 at 8:00 AM, on a tour of the kitchen dry storage area with the Certified Dietary Manager (CDM), a clear, large cylindrical container was found stored directly inside the bulk flour container. The container was in direct contact with the flour. The container showed visible flour residue on the outside, indicating repeated placement inside the bulk flour. On 4/20/26 at 8:05 AM, the CDM confirmed containers were not supposed to be stored inside bulk flour and acknowledged this practice was not consistent with facility policy. He stated utensils and scoops were required to be stored outside of dry goods to prevent cross-contamination. Later that day, on 4/20/26 at 1:55 PM, the CDM confirmed staff were expected to store scoops and utensils outside of bulk dry goods at all times and stated this expectation had been reviewed with staff previously. On 4/20/26 at approximately 8:49 AM, a Regional Kitchen Manager was standing at the tray cart with uncovered food items next to him. The Regional Manager had a full beard but did not utilize a cover over his facial hair in close proximity to exposed, ready-to-serve food. He engaged in close physical contact with kitchen staff, including hugging, while in the food service area. The Regional Kitchen Manager explained he had just arrived and confirmed he should have donned a beard guard before coming into the kitchen. Later that day, on 4/20/26 at 9:10 AM, the CDM acknowledged all staff, including regional and visiting staff, were required to follow facility hygiene and personal protective equipment (PPE) policies. He stated beard covers were required when handling or being near exposed food and acknowledged the Regional Manager should not have been near uncovered the food without proper facial covering.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a midline intravenous (IV) catheter had appropriate care including dressing changes and monitoring in accordance with professional standards of practice, for 2 of 2 residents reviewed for parenteral fluids/IVs, of a total sample of 48 residents, (#4, and #16). Findings: 1. Review of resident #16's medical record revealed resident #16 was initially admitted on [DATE] with diagnoses of urinary tract infection. On 4/20/26 at 8:50 AM, resident #16 was sitting in chair in a breakfast area awaiting breakfast. The resident had a clear midline IV catheter dressing which contained a small piece of gauze with dried rusty brown colored substance which resembled dried blood underneath the dressing. The clear dressing was dated 4/18/26. His IV line was connected to a bag of fluids which was running, and the bag was covered for dignity. The resident stated he did not recall staff changing the dressing since the IV was placed a few days ago. A midline is a type of IV catheter usually in your upper arm designed for people who need IV therapy lasting one to four weeks or whose veins are difficult to access with a regular IV. A common complication of midline IV's are infection, (retrieved on 5/06/26 from www.scienceinsights.org). Review of resident #16's current physician orders revealed orders for normal saline flush orders dated 4/20/26, and IV antibiotic orders dated 4/19/26. There were no orders for midline IV catheter care, assessment, dressing changes or IV fluids. Review of the Treatment Administration Record for April 2026 revealed no documentation by staff of any dressing changes, assessments, or catheter care. On 4/20/26 at approximately 2:52 PM, Licensed Practical Nurse (LPN) A confirmed resident #16's midline IV dressing dated 4/18/26 with the dried rusty brown substance on the small gauze, underneath the clear dressing. The LPN confirmed the resident was receiving one liter of normal saline which was indicated it was administered on 4/20/26 at 6:00 AM as written in black marker on the bag. LPN A stated the fluids were started before her shift. A few minutes later at approximately 2:55 PM, LPN A and the Staff Development Coordinator were at the nurse's station and reviewed resident #16's medical record. They confirmed resident #16's midline dressing had not been changed since it was inserted. They stated there were no orders related to the care of the resident's midline IV, such as dressing changes or monitoring of the site. The LPN and Staff Development Coordinator acknowledged there was no documentation of monitoring the IV site nor care of the resident's IV catheter. The Staff Development Coordinator stated that IV dressings changes were done 24 hours after initial insertion to prevent possible infection, then the dressing should be changed at least every seven days or as needed. 2. Review of resident #4's medical record revealed she was initially admitted on [DATE] with diagnoses of Extended-Spectrum Beta-Lactamase (ESBL), Klebsiella pneumoniae wound infection to her bilateral heels. Review of resident #4's current physician orders on 4/20/26 at 12:25 PM, revealed an order to re-insert the midline IV dated 4/17/26. There were no other physician orders for the midline IV. Further review of resident #4's April 2026 TAR showed no documented care or assessment for the midline catheter for dressing changes, monitoring or flushes. On 4/20/26 at approximately 2:42 PM, LPN A confirmed the rusty brown colored substance on the gauze underneath resident #4's clear IV catheter dressing with a date of 4/17/26. She acknowledged midline IV dressings should be changed 24 hours after insertion and at least every seven days after that for infection control and patency of the line. At approximately 2:55 PM, LPN A and the Staff Development Coordinator reviewed resident #4's medical record and confirmed there were no physician orders for care of her midline IV such as flushes, dressing changes or monitoring the IV site for signs and symptoms of infection or leaking. They both confirmed resident #4's IV dressing had not been changed since it was inserted on 4/17/26, nor was there documentation of any care or monitoring in the record. On 4/21/26 at 3:55 PM, the Director of Nursing (DON), stated nurses should place orders for a newly placed IV to include monitoring the site for signs and symptoms of infection, changing the dressing after the first 24 hours of insertion, weekly and as (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed dressing changes and flushes. Review of the policy, Guidelines for Preventing Intravenous Catheter - Related Infections revised August 2014 revealed, the insertion site should be observed every shift and with dressing changes. The policy detailed the initial IV dressing should be changed within 24 hours of placement then every five to seven days or as needed. The documentation section indicated objective information regarding appearance of insertion site, catheter, dressing, and any interventions done should be recorded in the resident's medical record.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to adhere to proper infection control practices related to transmission-based precautions for 1 of 3 residents reviewed on isolation for infection control, of a total sample of 48 residents, (#4).Findings:Review of resident #4's medical record revealed she was initially admitted on [DATE] with diagnoses of Extended-Spectrum Beta-Lactamase (ESBL), Klebsiella pneumoniae wound infection to her bilateral heels.Review of resident #4's current physician orders revealed the resident was placed on contact isolation every shift for ESBL in the heel wounds on 4/20/26 at 8:41 AM.ESBL infections are resistant to common antibiotics and may require complex treatments, good hand hygiene and infection prevention practices can help reduce infection risk, (retrieved on 4/24/26 from www.cdc.gov).On 4/20/26 at 11:43 AM, resident #4 was in bed awake and alert. A sign on the door indicated the resident in bed A (resident #4) was on transmission-based precautions (TBP), this signage specified the type of precaution being contact, and that personal protective equipment (PPE) including gown and gloves must be used before entering the room for the A bed. A few minutes after 11:43 AM, the Social Service Assistant entered the room without donning a gown or gloves even though the sign on the door indicated the resident was on contact precautions. The Social Service Assistant went to the side of resident #4's bed, shook her hand while speaking to her then proceeded toward resident #4's roommate who was in a wheelchair near the window. The assistant patted the roommate, who was not on contact precautions, on her shoulder with her bare hand, then went to the bathroom, washed her hands and exited the room.On 4/20/26 a short time later at approximately 11:46 AM, the Director of Nursing (DON) was standing outside resident #4's room. The DON confirmed the Social Services Assistant entered the room without donning gown or gloves and then addressed the assistant once she exited the room. The Social Service Assistant explained she had not noticed the resident was on contact isolation and directed the assistant to the sign on the door.Review of the Categories of Transmission-Based Precautions policy revised on October 2018, revealed under contact precautions staff would wear gloves when entering room, gloves would be removed and hand hygiene performed before leaving room. The policy specified staff would wear a disposable gown upon entering the room, remove the gown before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown was removed.		