

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Aviata at Kissimmee Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 W Donegan Ave Kissimmee, FL 34741	
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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor a resident's preference and did not respond timely to resident's request for a Coronavirus Disease 2019 (COVID-19) booster vaccine for 1 of 4 residents reviewed for choices, of a total sample of 40 residents, (#113). Findings: Review of the medical record revealed resident #113, a [AGE] year-old female, was originally admitted to the facility on [DATE] and readmitted from an acute care hospital on [DATE]. Her diagnoses included cerebra ischemia (stroke), type 2 diabetes, insomnia, and anxiety disorder. Review of resident #113's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date of 10/13/25 revealed a Brief Interview for Mental Status score of 14 out of 15, indicating intact cognition. The MDS assessment noted no behavioral symptoms and no rejection of care or treatment during the look-back period. On 1/12/26 at 9:51 AM, resident #113 stated she requested a COVID-19 booster vaccine in October 2025 and was still waiting to receive it. She reported she was told the vaccine was not available. On 1/14/26 at 9:50 AM, Registered Nurse (RN) F stated resident #113 mentioned she wanted to receive the COVID-19 booster vaccine. RN F indicated she spoke with the Infection Preventionist (IP), who told her the vaccine had already been administered. RN F explained nursing staff provided education regarding vaccines and, at times, obtained consent, while the IP was responsible for follow up and administration of the vaccines. Review of resident #113's medical record revealed an Informed Consent for COVID-19 Vaccine form dated 11/04/25. The form showed resident #113 consented to receive the COVID-19 vaccine. The form was signed by the IP and documented the verbal consent from resident #113. Review of resident #113's November 2025 Medication Administration Record (MAR) revealed COVID-19 vaccine order was entered on 11/12/25 but was not administered. The MAR showed a COVID-19 order was again entered on 11/17/25 with code 9 documented, indicating Other / See Nurse Notes. Review of resident #113's Progress Notes revealed a note dated 11/17/25 indicating the facility was waiting on the pharmacy for the COVID-19 vaccine booster. On 1/14/26 at 11:39 AM, the IP stated approximately 15 residents wanted to receive the COVID-19 booster vaccine. She indicated physician orders were obtained; however, the vaccines were not acquired due to insurance-related issues and cost concerns. She stated the issue was being handled by the finance department and the Director of Nursing (DON). The IP acknowledged resident #113 wanted the COVID-19 vaccine and stated the resident was upset with her for not administering it. On 1/15/26 at 11:00 AM, the IP further stated that on 12/16/25, she and the DON received a list from the Finance Manager identifying residents with Medicare Part B coverage that may pay for the vaccine. She acknowledged she did not follow up regarding resident #113's request for the COVID-19 vaccine. She also stated she did not have access to the pharmacy online system and indicated that during her nearly three years at the facility, she had not ordered or administered COVID-19 vaccines. On 1/15/26 at 11:34 AM, the DON explained once consent was obtained and a physician order was issued, an order should be entered into the system to obtain the vaccine from the pharmacy. She stated influenza and pneumonia vaccines typically arrived within three to five days once ordered, but COVID-19 vaccines could take longer, due to authorization requirements through Medicare Part B or (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: 106074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Aviata at Kissimmee Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 W Donegan Ave Kissimmee, FL 34741	
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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other insurance. She indicated she needed to verify timeframes with the IP. On 1/15/26 at 1:23 PM, during a telephone interview, the Pharmacy Representative stated COVID-19 vaccine orders were submitted using an electronic form, the same process used for influenza vaccines. Upon review of her system, she indicated she did not see any COVID-19 vaccine orders submitted by the facility. She stated if the vaccine was not ordered electronically with the correct form, the pharmacy would not dispense it, and the facility would need to follow up. She further stated COVID-19 and influenza vaccines were ordered as bulk vaccines and were not resident-specific. On 1/15/26 at 2:15 PM, in a joint interview with the Administrator (NHA) and the DON, both stated they were not aware of any issues related to obtaining or administering COVID-19 vaccines. The NHA shared the IP attended daily stand-up and Quality Assurance and Performance Improvement meetings and had not raised any concerns. The NHA stated she expected the IP to manage all aspects of the immunization process. Later, at 2:55 PM, the NHA stated she spoke with the Pharmacy General Account Manager, who confirmed the IP had access to place vaccine orders electronically. The NHA indicated Pharmacy General Account Manager was unable to identify the last date COVID-19 vaccines were ordered. The NHA stated the IP had received the same pharmacy training as other nursing management staff when the facility contracted with the pharmacy provider approximately one year earlier. Review of the facility's policy titled COVID-19 Vaccine - Resident, revised 11/17/21, revealed the vaccine was to be offered to residents and ordered through the pharmacy partner, local or state public health agency, or through arrangements with a vaccine provider to administer the vaccine. Review of the facility's policy titled Resident Rights, dated 11/30/24, revealed the facility's intent to ensure resident rights were known to staff.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Aviata at Kissimmee Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 W Donegan Ave Kissimmee, FL 34741	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain accurate documentation for application and removal of Thromboembolic Deterrent (TED) hose for 1 out of 1 residents sampled for application of TED hose, of a total sample of 40 residents, (#45). Findings: TED hose are stockings that help prevent blood clots and swelling in your legs, (retrieved from www.drugs.com on 1/16/26). Resident #45 was admitted to the facility on [DATE] with diagnoses that included partial weakness and paralysis after a stroke affecting the right dominant side, heart disease, altered mental status and major depressive disorder. A review of the Annual Minimum Data Set (MDS) assessment with reference date 10/19/25 revealed resident #45 had a Brief Interview for Mental Status Score of 13 out of 15, which indicated normal cognition. A review of the medical record revealed on 12/10/25 change in condition documentation of pitting edema in the right lower leg for resident #45 and physician's orders initiated on 12/10/25 directing nursing staff to apply TED stocking on in the morning and off at night for venous stasis. The Medication Administration Record (MAR) revealed that nurses checked off that TED hose stockings were applied and removed from 12/10/25 to 1/13/26 with the exception of the date 12/28/25. There was no corresponding documentation in the nurses' progress notes about resident # 45's refusal to wear the TED hose, nor was there an issue with supply nor size of resident #45's TED hose. On 1/12/26 at 10:31 AM, resident #45 was in his wheelchair in the hallway and was not wearing the TED hose. The MAR for that day indicated documentation that showed the hose was applied. On 1/13/26 at 2:49 PM, resident #45 was in bed and was not wearing the TED hose stockings. He stated he did not wear the TED hose but did not give a reason why. The MAR for 1/13/26 contained documentation the hose was applied. On 1/13/26 at 4:00 PM, in a joint interview with assigned RN B and the Sunflower Way Unit Manager (UM), the RN acknowledged resident #45 did not have the physician ordered TED hose on. The nurse stated he was not aware of the order for the TED hose and explained possibly it was a new order. He confirmed the MAR with his documentation that the TED hose had been applied on 1/12/26 and for that day, 1/13/26. He was unable to say why he had checked off that the hose was applied and said he may have checked it off in error. RN B confirmed the documentation in the record was incorrect and should not show the TED hose was applied to the resident on 1/12/26 and 1/13/26. At that time, the UM verified together with RN B confirmed the physician order was not new and was placed on 12/10/25. The UM verified another mistake in the medical record, when the nurse on the night shift had incorrectly documented she removed the stockings on 1/12/26 even though they were never applied. On 1/13/26 at 4:10 PM, RN E in a telephone call, did not recall what happened but explained she must have documented in error. On 1/13/26 at 4:17 PM, the Sunflower Way UM acknowledged the documentation on the MAR was incorrect for 1/12/26 and 1/13/26. With the resident's permission to look into his drawers, the UM found the TED hose. Resident #45 stated he had never worn them, and he did not wish to wear them. The UM verified the physician should be notified the resident did not wish to wear the ordered TED hose. On 1/14/26 at 11:30 AM, the assigned Certified Nursing Assistant (CNA) C said that resident #45 often refused care, would refuse to wear his brace, and did not wear the TED hose. The CNA said she did not recall putting the hose on him. 1/14/26 at 12:47 PM, resident #45's sister and his POA stated she visited once or twice a week and had never seen resident #45 with the TED hose on. On 1/15/26 at 2:45 PM, the Director of Nursing and the Nursing Home Administrator acknowledged nurses were expected to accurately document whether orders were implemented in the medical record and not simply check off boxes. The facility's policy on Clinical/Medical Records revised on 8/25/17 indicated that clinical records were maintained in accordance with professional practice standards to provide complete and accurate information on every resident for continuity of care.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Aviata at Kissimmee Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 W Donegan Ave Kissimmee, FL 34741	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow appropriate hand hygiene during medication administration and failed to sanitize equipment between residents per infection control standards to prevent cross-contamination and the spread of infection, for 1 of 4 nurses reviewed for medication administration. Findings: On 1/13/26 at 9:00 AM, Licensed Practical Nurse (LPN) A was observed for a medication pass on resident #128. She took resident #128's blood pressure, set the used cuff on top of her cart, but did not clean or sanitize it. The nurse made two trips to the medication room, touched the medication machine, handled the medications, but did not perform any hand hygiene. She entered the resident's room three different instances passing the hand sanitizer dispenser located to the right of the doorway each time. There was also a full bottle of alcohol-based hand sanitizing solution on her cart, which she did not use. On 1/13/26 at 9:18 AM, LPN A confirmed she was aware she should sanitize her hands with alcohol-based hand sanitizing solution each time she entered or exited a room. She said, I forgot, I'm so sorry. On 1/14/26 at 11:42 AM, the Infection Preventionist confirmed all staff had regular training on infection prevention including hand hygiene. She said staff were expected to perform hand hygiene before they handled medications, before and after they put on gloves, between residents, before they go into the medication room, and after they come out of any room, to avoid contamination. The Infection Preventionist explained that sometimes staff got busy and forgot but stressed that handwashing was important to prevent germ transmission. Review of the 2025 education log revealed all staff were educated on infection control once a month for the last year, excluding the month of September. On 1/15/26 at 10:45 AM, the Director of Nursing explained the best way to control infection, We have educated our staff since the day they were hired on hand hygiene, personal protective equipment, and to clean equipment before and after use. Review of the Hand Hygiene policy dated 2/05/21 read, Hand hygiene should be performed before and after patient care, after contact with inanimate objects (including medical equipment), and antiseptic hand wash or rub may be used. Review of the Medication - Oral Administration policy and procedure, dated 8/15/19 directed staff to, Perform hand hygiene prior to [when] administration begins.		