STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105132	A. Building B. Wing	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Lakeside Oaks	1061 Virginia St Dunedin, FL 34698

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure the grievance process was followed by failing to document a grievance for one resident (#4) out of three residents reviewed. Findings included: Review of Resident #4's admission record revealed an admission date of 10/29/24 with diagnoses to include type 2 diabetes, muscle weakness, seizures, paranoid schizophrenia, bipolar disorder, major depressive disorder, brief psychotic disorder, and anxiety disorder. A review of Resident #4's Minimum Data Set (MDS) dated [DATE], section C revealed a brief interview for mental status (BIMS) score of 13, meaning cognitively intact. A review of a statement completed by Staff A, Registered Nurse (RN) on 9/7/25 with Resident #4, related to a reportable incident, revealed the resident expressed they do not always feel safe or comfortable at the facility due to Certified Nursing Assisting (CNA) staff mishandling and being rough with her. A review of the facility's grievance log revealed there was no grievance initiated for Resident #4 regarding her concern expressed to Staff A, RN on 9/7/25. A review of Resident #4's progress notes revealed there was no documentation regarding the resident's statement on 9/7/25. Review of the training records revealed a grievance training was conducted on 8/5/25. Out of eighty-six (86) total staff members, thirty-six (36) staff members did not attend the training including the Activities Director; Staff A, CNA; Staff E, CNA; Staff F, CNA; Staff G, CNA; Staff H, CNA; Staff I, CNA; and Staff J, CNA. An interview with Staff C, CNA on 10/20/25 at 10:36 a.m., revealed she completes a voiced concern by a resident only if she feels like one needs to be filled out. She said she did not complete a grievance for every concern that is voiced to her. An interview with Staff C, CNA on 10/20/25 at 10:36 a.m., revealed having never received grievance training before, for at least eight years. Staff C said she had never written a grievance before. An interview with the Nursing Home Administrator (NHA) on 10/20/25 at 4:50 p.m. revealed Resident #4 was typically easily gets upset, and is, Usually very dramatic when needing something. The NHA expressed she did ask Resident #4 about the complaint made during the investigation from 9/7/25 but did not complete an investigation or document anything about the concern that was voiced by Resident #4. On 10/20/25 at 5:50 p.m., an interview with the Social Services Director (SSD) revealed any voiced concern should be documented as a grievance. The SSD stated there are no parameters in what should be considered a grievance or not. The SSD expressed that he regularly goes around asking the CNA's if they have heard of any recent concerns, and he will write up the grievance himself if the nurse or CNA does not want to themselves. The SSD explained a nurse or CNA might not write up a grievance on their own due to lack of education on grievances or if the individual might feel like they cannot or should not write the grievance. When the SSD was asked if completing grievances should be based on an employee's discretion, the SSD stated the grievance would matter more on the concern rather than the individual's discretion. The SSD explained the only time discretion should be made is if the nurse or CNA came to him and let him make the determination on whether a grievance should be made or not. The SSD stated that he, doesn't really know who does or does not know about the grievance process. When asked if a grievance is filed when there is an allegation of abuse, the SSD explained that a grievance and reportable should be completed in reference to the allegation, as the situation needs to be rectified. The SSD explained that any concerns about residents being handled roughly during care should be addressed with the nursing department, and a grievance should be made and processed. A review of the facility's grievance policy revealed: The center will make prompt efforts to resolve the complaint/grievance and informed the resident of progress towards resolution. Grievances will be reviewed by the Quality Assurance Performance Improvement Committee. Grievances discovered to meet the definition of Abuse, Neglect, Exploitation or Misappropriation will be handled per the facility's Abuse Policy. The resident should have reasonable expectations of care and services, and the center should address those expectations in a timely, reasonable, and consistent manner. An employee receiving a complaint/grievance from a resident, family member and/or visitor will initiate a Complaint/Grievance Form. Accommodations will be made to ensure residents have the opportunity regardless of their physical abilities or limitations. Original grievance forms are then submitted to the Grievance Officer/designee for further action. The Grievance Officer/designee shall act on the grievance and begin follow-up of the concern or submit it to the appropriate department director for follow-up. The grievance follow-up should be completed in a reasonable time frame, this should not exceed 14 days. The Grievance Officer will log complaints/grievances in Monthly Grievance Log. The individual voicing the grievance will receive follow-up

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interviews and record review, the facility did not ensure two allegations of abuse were investigated thoroughly for two residents (#1 and #2) out of four residents with reportable incidents reviewed.Findings included: 1.) On 10/21/25 at 10:58 a.m., an interview was conducted with Resident #1. She said an event occurred at the facility on 9/4/25. She said she had a bowel movement and relied on the staff to change her. She said around 5:00 or 6:00 p.m., on 9/4/25, she requested a female staff to assist with changing her. Resident #1 said she was told by a male staff the female staff member was busy, and she could wait until about 7:30 p.m. She said she was not comfortable with a male staff member changing her. Resident #1 said her response was she was not waiting for two hours to be changed. She said Staff I, Certified Nursing Assistant (CNA) was the only person available to assisting with changing her soiled brief. She said she ambulated in the wheelchair to her room and waited. Resident #1 said Staff I, CNA came in and assisted her into bed. She said she rolled to the side to be changed. Resident #1 said she has a catheter and when Staff I, CNA was cleaning that area she felt a lot of pressure towards her anus. She said she asked him what he was doing and continued to feel more pressure. Resident #1 said she felt Staff I, CNA's fingers enter her genital area. She stated, I swatted him and told him to get me dressed. She said she felt embarrassed afterwards and called her family members. Resident #1 stated, I didn't want to do anything, and I wanted to act like it didn't happen. She said she felt she did not have anyone to talk to. She said she told Staff J, Licensed Practical Nurse (LPN) about the incident on 9/6/25 and the nurse reported it. A review of Resident #1's admission record revealed an admission date of 8/15/25 with diagnoses to include intraspinal abscess and granuloma, other bipolar disorder, need for assistance with personal care, muscle weakness (generalized), neuromuscular dysfunction of bladder, unspecified, other psychoactive substance use, unspecified, uncomplicated, other specified anxiety disorders, other recurrent depressive disorders, and chronic post-traumatic stress disorder (PTSD).A review of Resident #1's comprehensive minimum data set (MDS), section C-cognitive patterns, dated 8/18/25 revealed a brief interview for mental status (BIMS) score of 15, meaning cognitively intact.A review of Resident #1's care plan initiated on 9/2/2025 revealed the following a focus - [Resident name] has potential for re-traumatization due to past history of trauma kidnapped and raped by [family member], multiple family suicide, trigger---loud noise, Date Initiated: 09/02/2025, with a goal of, [Resident name] triggers will be avoided, and resident will not be re-traumatized. Date Initiated: 09/02/2025 . Target Date: 12/01/2025. Interventions to include, Announcing self before entering, avoiding sudden movements Date Initiated: 09/02/2025. Avoiding noises/noisy environment Date Initiated: 09/02/2025. Do not talk about the event unless the resident wants to/initiates the conversation about the event, Date Initiated: 09/02/2025 . Giving resident control and choices, Date initiated 09/02/2025. Other: Psych services as indicated Date Initiated: 09/02/2025. A review of Resident #1's nursing progress note dated 9/7/25 revealed - Writer knocked on resident door & introduced herself & resident said come in; Writer asked how she is doing and she got a little teary and said she is still quite emotional & said she should have spoken up sooner; provided her comfort and reassurance that staff are here to support her and make her stay here pleasant & safe. Reminded her not to blame herself but to focus on her healing & therapy & recovery so she can go home when ready; Reminded her if she wants to talk anytime just let me know and I will be right there.A review of Resident #1's nursing progress note dated 9/7/25 revealed, When writer went into resident's room to give resident IV [intravenous] writer asked how she was feeling resident stated, emotional that it was a long day resident started to cry very upset. Writer assured resident that she was safe resident applied for waiting so long to report the situation and started to cry again writer tried to comfort resident, stating that it is understandable due to situation. Resident is in good spirits to see [family member] in morning.A review of Resident #1's nursing progress note dated 9/8/25 revealed a medication administration note, 0-no behavior, 1-agitation, 2-combative, 3-verbally inappropriate, 4-sexually inappropriate, 5-crying, 6-calling out, 7-screaming, 8-hallucinations, 9-delusions, 10-resists care, 11-socially inappropriate, 12-other see progress notes . 5 resident crying off and on.A review of Resident #1's progress note dated 9/9/25 revealed an encounter note, Date of Service: 09/09/2025 . Today, I saw patient as it was reported to me that patient is unstable requiring psychiatric assessment. Due to acuity of the situation, I saw patient using Telepsych [telehealth psychiatry] . The facility requested a psychiatric assessment to evaluate for trauma following an abuse allegation involving a staff member. The resident was cooperative and engaged during interview. She endorsed a history of PTSD related to prior kidnapping and sexual assault

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F 0699 Level of Harm - Actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. (continued on next page)

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F 0699 Level of Harm - Actual harm Residents Affected - Few	Based on observation, record review, and interviews, the facility did not ensure the care plan was updated and individualized interventions were in place after a reportable adverse event, that resulted in re-traumatization, for one resident (#1) out of one resident reviewed.Findings included: On 10/21/25 at 10:58 a.m., an interview was conducted with Resident #1. She said an event occurred at the facility on 9/4/25. She said she had a bowel movement and relied on the staff to change her. She said around 5:00 or 6:00 p.m., on 9/4/25, she requested a female staff to assist with changing her. Resident #1 said she was told by a male staff the female staff member was busy, and she could wait until about 7:30 p.m. She said she was not comfortable with a male staff member changing her. Resident #1 said her response was she was not waiting for two hours to be changed. 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Date Initiated: 09/02/2025 . Target Date: 12/01/2025. Interventions to include, Announcing self before entering, avoiding sudden movements Date Initiated: 09/02/2025. Avoiding noises/noisy environment Date Initiated: 09/02/2025. Do not talk about the event unless the resident wants to/initiates the conversation about the event, Date Initiated: 09/02/2025 . Giving resident control and choices, Date initiated 09/02/2025. Other: Psych services as indicated Date Initiated: 09/02/2025.Another focus in the same care plan revealed - [Resident name] is at risk for behaviors r/t [related to] use of psychoactive medication, Bipolar, PTSD, history of drug abuse Date Initiated: 09/02/2025.Another focus in the same care plan revealed - [Resident name] has a mood problem r/t Admission/bipolar, PTSD Date Initiated: 09/02/2025 Revision on: 09/02/2025.Review of the care plan and the electronic medical record (EMR) revealed no documentation about Resident #1's preference of no male caregivers. A review of Resident #1's progress note dated 8/21/25 revealed, encounter, Date of Service: 08/21/2025 . Psychiatry Evaluation Note . Chief Complaint: Depression, anxiety, Bipolar and PTSD. Reason for Today's Evaluation: I was consulted for psychiatric evaluation and treatment of depressed mood. History of Present Illness: . Past psychiatric history of depression, anxiety, Bipolar and PTSD . Patient reports she's a little depressed and having intermittent trouble sleeping. She has been having mood swings and outburst with the staff. Patient does not want to change or adjust any medications at this time, however she is open to psychotherapy. According to PHQ9 [patient heath questionnaire-9] score is 11 that is moderate depression and BIMS score of 15, which is cognitively intact. Insight and Judgement: Intact Orientation: Alert, Oriented X 3 . Assessment and plan for trauma: History of trauma: Kidnapped and raped by [family member], multiple family suicide. Current triggers if any: Loud noise, PTSD status: No PTSD diagnosis Care plan if trauma and triggers present: Continue ability, refer to psychotherapy . Added PTSD dx [diagnosis] and care plan in the chart: As pt. (patient) has active symptoms of PTSD such as flashbacks, nightmares, hypervigilance causing distress, .A review of Resident #1's nursing progress note dated 9/7/25 revealed - Writer knocked on resident door & introduced herself & resident said come in; Writer asked how she is doing and she got a little