STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105258	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at the Sea - Pompano Beach	2401 NE 2nd Street Pompano Beach, FL 33062

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a PASARR (Preadmission Screening and Resident Review) Level I was completed for a resident with mental disorders who was [NAME] Act to the hospital due to a crisis state of violent/aggressive behaviors and then was readmitted to the facility for 1 of 1 sampled resident (Resident #2). The findings included: Review of the facility's policy titled, Preadmission Screening and Resident Review (PASARR), dated 11/08/21, included the following: the center will assure that all Serious Mentally Ill (SMI) and Intellectually Disabled (ID) residents receive appropriate pre-admission screenings 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 screenings, 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. 6.Recommendations will be incorporated in the individual resident's plan of care and approaches/interventions developed to meet the identified needs of the individual. 7.Social Services will be responsible for coordinating significant change updates of these screenings, conducted by the appropriate agency. These results, along with the results from previous years will be kept in the appropriate sections of the resident's records. Record review revealed Resident #2 was admitted to the facility on [DATE], had a [NAME] Act discharge date d 06/09/25 and readmitted to the facility on [DATE]. Resident #2 had another [NAME] Act discharge on [DATE], readmitted to the facility on [DATE] and discharged to another facility on 06/24/25. On 06/16/25 Resident #2 had a Brief Interview for Mental Status (BIMS) score 13/15, indicating no cognitive impairment. Record review of Resident #2's medical diagnoses on admission indicated that she had a history of Major Depressive Disorder; Mood Disorder; Adjustment Disorder with Mixed Anxiety and Depressive Mood; Bipolar Disorder and Human Immunodeficiency Virus (HIV) Disease. (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical records revealed Resident #2's last PASARR Level I was completed on 04/22/25 and no recommendation for PASARR Level II. Review of Resident #2's Psychiatry Progress Note dated 06/09/25 included the following documentation: Resident #2 had been manic, grandiose, intrusive, psychotic, delusional and refusing to follow staff recommendations to keep her safe. She is HIV positive and has been spitting at staff and refusing all medications. She has a history of Bipolar with psychosis seen today for [NAME] Act. On 06/13/25 Resident #2 returned to the facility and was seen by psychiatry on 06/14/25, included the following progress note: Resident #2 was seen after returning from [NAME] Act although she continues to be agitated, trying to spit at others, increased behavioral disturbances. She was able to be redirected; however, a change of room was required because she was becoming aggressive toward her roommate as well. Record review of Social Services (Social Worker (SW)) progress notes from 06/09/25 to 06/24/25 revealed no assessment or documentation by SW regarding the [NAME] Act and no PASRR Level I was completed for Resident #2 prior to readmission on [DATE]. On 06/18/25, Resident #2 was again [NAME] Act due to increased bipolar disorder symptoms and homicidal ideations. During an interview on 07/01/25 at 11:48 AM with the Director of Social Services (DSS), who stated she has been working at the facility for over 3 months. The DSS stated those residents that are [NAME] Act and return to the facility will have a completed PASARR Level I and it would be included in the hospital paperwork upon readmission. If the PASARR is incorrect or missing, the DSS stated she will have to do a new one for the resident. The DSS was then asked about the PASARR for Resident #2 when she returned from [NAME] Act dated 06/09/25. She then stated that Resident #2 was not [NAME] Act on 06/09/25 but on 06/18/25. A side-by-side review of Resident #2's census and psychiatric notes revealing Resident #2 was transferred to the hospital twice in the month of June, which included 06/09/25. The DSS acknowledged that she was not aware of Resident #2 going out on 06/09/25 for [NAME] Act and will look for the PASARR in the hospital paperwork. She later returned with a PASARR Level I completed on 04/22/25 (none for the month of June) and stated that this one was the latest PASARR for Resident #2. During an interview conducted on 07/01/25 at 3:45 PM with the regional nurse, who stated that the facility's social service director is responsible to assure the resident had the PASARR level I after returning to the facility on [DATE] from a [NAME] Act discharge.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to revise the care plan for a resident with recent increased violent/aggressive behaviors towards other residents and staff for 1 of 1 sample resident reviewed for mental disorders (Resident #2). The findings included: Review of the facility's policy titled, Plans of Care, revised date 09/25/17, included the following: 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 the state and federal regulatory requirements. Plan of care is to be maintained as part of the final medical record. 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 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. Record review revealed Resident #2 was admitted to the facility on [DATE], had a [NAME] Act discharge date d 06/09/25 and readmitted to the facility on [DATE]. Resident #2 had another [NAME] Act discharge on [DATE], readmitted to the facility on [DATE] and discharged to another facility on 06/24/25. On 06/16/25 Resident #2 had a Brief Interview for Mental Status (BIMS) score 13/15, indicating no cognitive impairment. Record review of Resident #2's medical diagnoses on admission indicated that she had a history of Major Depressive Disorder; Mood Disorder; Adjustment Disorder with Mixed Anxiety and Depressive Mood; Bipolar Disorder and Human Immunodeficiency Virus (HIV) Disease. Review of the Nursing behavior note dated 06/06/25 documented Resident #2 wheeled herself to two nurses in the hallway and spit on one of the nurses, Resident #2 ignored the nurses and took the elevator downstairs. On 06/07/25 Resident #2 was observed wheeling herself around facility and when passed a nurse she kicked her and hitting other staff with her wheelchair when passing by them. On 06/09/25 the behavior note documented Resident #2 continues to be combative during morning care and spitting at the staff. Review of Resident #2's Psychiatry Progress note dated 05/29/25 included the following documentation: According to staff, Resident #2 has shown increased symptoms of bipolar disorder. On 06/05/25, a follow up visit documented: The resident was seen today as per staff requested due to aggressive behavior. The resident is irritable most of the time, per staff. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's Psychiatry Progress Note dated 06/09/25 included the following documentation: Resident #2 had been manic, grandiose, intrusive, psychotic, delusional and refusing to follow staff recommendations to keep her safe. She is HIV positive and has been spitting at staff and refusing all medications. She has a history of Bipolar with psychosis seen today for [NAME] Act. On 06/13/25 Resident #2 returned to the facility and was seen by psychiatry on 06/14/25, included the following progress note: Resident #2 was seen after returning from [NAME] Act although she continues to be agitated, trying to spit at others, increased behavioral disturbances. She was able to be redirected; however, a change of room was required because she was becoming aggressive toward her roommate as well. On 06/18/25, Resident #2 was again [NAME] Act due to increased bipolar disorder symptoms and homicidal ideations. Record review revealed the last Interdisciplinary Team (IDT) meeting for Resident #2 was held on 05/07/25 (Care plan conference) in which the resident was noted to have decline in mental status. Review of the Care Plan revised on 05/27/25 documented Resident #2 had behaviors of refusing medications, meals, and blood work. It also documented a history of attempting to access food trays that are not assigned to her and hitting staff, with goals and interventions only addressing resident's refusal of medications. No other behaviors were documented or addressed in the care plan. During an interview on 07/01/25 at 4:39 PM with the MDS coordinator, who stated she has worked at the facility for 2 weeks. She stated they hold morning clinical meetings daily and residents with concerns are reviewed. When asked who attends these meetings, she stated the Activity director, Dietary, social worker, Administrator and Director of Nursing (DON). She stated if a resident is [NAME] Act, all departments try to see the resident the next day of readmission to gather information, and any issues are discussed during the daily clinical meeting. She then added, the departments have 24 hours to update anything for the residents in their medical records. Then, she stated [NAME] Act information goes under behavior progress notes by Social Services for the resident. When she was asked why Resident #2's care plan was not revised after a change in condition, she noted that for it to be a change in condition it needs to effect the activities of daily living (ADLs); if there's a change in the resident's behavior, this may not necessarily be a change in condition since it can or cannot effect the ADLs. She then confirmed that any change in the resident's behavior is discussed between nursing and social services and reviewed during the daily morning meeting. She acknowledged that Resident #2's care plan was not revised even though the resident had a change in condition and stated social services would be the one to revise the care plan. During an interview conducted on 07/01/25 at 3:45 PM with the regional nurse, who stated that the facility's social service director is responsible to assure Resident #2 care plan is revised and updated to reflect their behaviors and needed interventions.