STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105394	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at the Palms	2600 Highlands Blvd N Palm Harbor, FL 34684

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and interviews the facility failed to provide a homelike, safe, clean and sanitary, and pest free environment for four (#7, #16, #17, #18) out of four residents reviewed. Findings included:1. On 4/13/2026 at 10:32 AM an observation was made of the facility's maintenance shed full of debris on the inside; a toilet, a black bin with garbage in it, wooden platforms stacked on one another, a bathroom commode, a wheelchair, an opened safe, two large-industrial portable air conditioning units with bio growth present, multiple garbage cans, and carts scattered around the shed.On 4/13/2026 at 10:34 AM an interview was conducted with Staff L, Maintenance Assistant (MA). Staff L, MA stated they are waiting for the Maintenance Director to come up with a solution for all of the supplies and items present outside of the maintenance shed and is waiting for direction on what to do with the items outside of the shed since the shed is full.2. On 4/13/2026 at 11:07 AM an observation was made of the facility's grounds. Inspection of the ground revealed a large broken window of a residents room, wasps nests between windows and the screen, and fallen gutter pieces not disposed of properly. Outside of the facility's kitchen door was a wheelchair, empty plastic bins, a shop vacuum, garbage can lids, and plastic trays thrown on the grounds of the facility.On 4/13/2025 at 7:50 PM an interview was conducted with Resident #7. The resident stated they do not know how their window broke but knows they woke up one morning in January to it being broken. Resident #7 stated they have told staff and maintenance about the window since the day it happened, but they have been slow with providing the repair.3. A review of Resident #17's admission record revealed an admission date of 2/21/2026 with diagnoses to include multiple rib fractures, a history of falling, and chronic pain syndrome.A review of Resident #17's Quarterly Minimum Data Set (MDS) assessment, dated 2/25/2026, in section C - cognitive patterns revealed a Brief Interview Mental Score (BIMS) of 15, indicating Resident #17 is cognitively intactOn 4/13/2026 at 11:45 AM an observation was made of a dead insect on the closet floor of Resident #17. Further examination of Resident #17's room revealed a large hole on the ground corner of the window wall with broken drywall present and crumbling base-boarding. Small pests were found under the bed of Resident #17's room. Resident #17 stated they always see roaches and bugs crawling around the room and their bed and the staff does nothing about it. Resident #17 stated they are always killing roaches and flies in their room.On 4/13/2026 at 11:32 AM an interview was conducted with Staff K, Licensed Practical Nurse (LPN). Staff K, LPN revealed some rooms have issues with pests and has seen roaches in the rooms of certain residents. Staff K, LPN stated anytime they see pests they are to fill out the sighting log that is left at each nurses station and let maintenance know so pest control can handle the room when they come in.On 4/13/2026 at 11:52 AM an interview and observation was made with Staff M, Certified Nursing Assistant (CNA). Staff M, CNA stated the pest in Resident #17's closet was a roach, as well as the pest under the other bed being a roach. Staff M, CNA moved the other bed in Resident #17's room and under the wheels of the bed revealed multiple pest debris and dust. Staff M, CNA stated pests are found in rooms of residents who have untidy rooms or a lot of food, or rooms with men in them. Staff M, CNA, was unaware of the pest sighting log present at each nursing station. Staff M, CNA stated (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they were not aware of the large hole in the wall of Resident #17's room so it was never reported to maintenance. 4. A review of Resident #18's admission record revealed an initial admission date of 5/9/2025 with diagnoses to include muscle weakness, major depressive disorder, and unspecified mood disorder.A review of Resident #18's Quarterly Minimum Data Set (MDS) assessment, dated 4/8/2026, in section C - cognitive patterns revealed a Brief Interview Mental Score (BIMS) of 13, indicating Resident #18 is cognitively intact.On 4/13/2026 at 12:19 PM an observation was made of Resident #18's room. The resident's room was messy with three pairs of shoes scattered on the floor, cups stacked within each other, other drinking cups on the floor, a pest living in the Resident's pack of personal care items, and a large hole present under the window of crumbling dry-wall along the floor next to Resident #18's bed. Resident #18 stated no one cares to fix his room and that he sees roaches present all the time.On 4/13/2026 at 12:19 PM an observation and interview was made with Staff O, CNA. Staff O, CNA stated it was a roach that was present in Resident #18's brief pack. Staff O, CNA stated Resident #18's room tends to have roaches present in it because of the constant condition of the room.5. On 4/13/2026 at 1:46 PM an observation was made of a pest trap in the corner of the facility's kitchen of their preparation table.On 4/13/2026 at 1:40 PM an interview was conducted with Staff N, Cook. Staff N, [NAME] stated despite not seeing any pests in the kitchen, they do know there are some traps present in the kitchen, but was not sure where6. A review of Resident #16's admission record revealed an initial admission date of 7/11/2024 and a re-admission date of 9/9/2025 with diagnoses to include difficulty walking, venous peripheral insufficiency, need for assistance with personal care, and anxiety disorders. A review of Resident #16's Quarterly Minimum Data Set (MDS) assessment, dated 3/25/26, in section C - cognitive patterns revealed a Brief Interview Mental Score (BIMS) of 15, indicating Resident #16 is cognitively intact. A review of Section B- Hearing, Speech and Vision revealed Resident #16 has highly impaired visionOn 4/13/2026 at 3:10 PM an observation was made of Resident #16's room revealing multiple pests present crawling underneath the residents bedside table. Resident #16 stated they live in terror of being crawled on in bed by the pests, especially because the resident is unable to see them due to loss of eyesight. Resident #16 stated their family is also aware of the pests. Resident #16 stated the light above their bed only works halfway and demonstrated the light switch. Only one light bulb was operational on the light. Resident #16 stated they have reported it to staff multiple times over a few months period, and nothing has been done yet. Resident #16 stated even though they have not been able to use their toilet in months due to recent diagnoses and conditions, the toilet has not been able to properly flush. Resident #16 explained once you flush the toilet once, you are unable to flush it again for at least 20 minutes, it just keeps running. Resident #16 stated they have told nursing about it, but nothing has been done about it. While observing Resident #16's toilet's flushing ability, two pest traps were present behind the toilet. During observation of Resident #16's room, a large gallon bottle of pest killer was found on the resident's bedside table. Resident #16 stated their family member brought it in because of how bad the pests were in the room.On 4/13/2026 at 4:00 PM while advising the NHA of Resident #16's toilet, the Adimistrator in Training (AIT) stated that it is Normal for all toilets, especially in the facility to have at least a 8 minute delay, and that it is normal to not be able to flush the toilet within a couple minutes after the initial flush.On 4/13/2026 at 4:06 PM an observation and interview was made with the Nursing Home Administrator (NHA), Director of Maintenance (DM) and the Regional [NAME] President Officer (RVPO) of Resident #16's room. The DM moved Resident #16's bedside table and found and identified multiple roaches crawling around the resident's wall and floor. Resident #16 stated having these pests in their room makes them feel itchy and uncomfortable knowing that they are crawling around and the resident is unable to see them. The NHA, DM, and RVPO started having Resident #16's room cleaned out immediately and stated they found more roaches behind the items hanging on the residents wall despite the room not being messy.On 4/13/2026 at 4:43 PM an observation and interview was made with the Transportation Director (TD). The TD is on angel-rounds for Resident #16 and visits their room daily. The TD stated during her (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	includes inspection, reporting, and prevention. Procedure: 3. Treatment will be rendered as required to control insects and vermin. 4. Any unusual occurence or sighting of insects should be reported immediately to the supervisor. Proper action will be taken.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on interviews and record review, the facility failed to ensure voiced concerns from resident council meetings were documented as a grievance and acted upon during two meetings (held on 1/5/26 and 2/4/26) out of three meeting minutes reviewed, as well as three food committee meetings (held on 3/10/26, 3/24/26, and 4/7/26) out of three meeting minutes reviewed.Findings included: On 4/13/26 at 1:40 p.m., an interview was conducted with Resident #23. He said Staff E, Activities Assistant documented the resident council minutes. Resident #23 said the residents expressed their concerns, they were written in the meeting minutes, but there was no follow-through or resolution. He said it was the same old and new business concerns every month.A review of Resident #23's minimum data set (MDS) assessment, dated 1/8/26, revealed under section C - cognitive patterns, a brief interview for mental status (BIMS) score of 15, indicating cognitively intact.On 4/13/26 at 1:58 p.m., an interview was conducted with Staff E, Activities Assistant. She confirmed she wrote down the resident council minutes by hand on a sheet of paper. Staff E, Activities Assistant said she gives them to the Activities Director who typed the notes and puts them in a binder. She said she did know what happened with the resident council minutes after she provided them to the Activities Director.The facility provided resident council minutes for 1/2026, 2/2026 and 4/2026, but did not provide 3/2026 meeting minutes.A review of the resident council meeting minutes revealed the following:- On 1/5/26 the resident council meeting conducted at 10:15 a.m., showed the following concerns were documented to include: housekeeping not cleaning resident rooms daily and poor customer service.- On 2/4/26 the resident council meeting conducted at 10:14 a.m., showed the following concerns were documented to include: staff using personal items such as cell phones and headphones, maintenance issues and lack of follow-through/resolution with reported issues, and housekeeping staff moving resident items then not putting them back and fitted sheets reported as too small.A review of the food committee meetings minutes revealed the following:- On 3/10/26 the meeting minutes showed the following concerns were documented to include: meal ticket and tray accuracy, lack of condiments on tray, and snacks not being offered at night.- On 3/24/26 the meeting minutes showed the following concerns were documented to include: food was overcooked, residents did not like canned fruit, and the taste of juice was described as too strong.- On 4/7/26 the meeting minutes showed the following concerns were documented to include: plates not hot, lack of condiments on tray, canned fruit consistency was too hard/difficult to chew, and snacks not consistently available.A review of the grievance logs for 1/2026, 2/2026 and 3/2026 did not show documented concerns for the resident council group or individual concerns for the residents who attended resident council meetings. Further review of the grievance logs did not show documented concerns from the food committee group or individual concerns for the residents who attend the food committee meetings. The review confirmed there were undocumented and unresolved grievances from resident council and food committee meetings.On 4/13/26 at 5:07 p.m., an interview was conducted with the nursing home administrator (NHA). He stated grievances, Could be from anyone. He said concerns are documented on the grievance log. The NHA said the majority of the grievances come from the facility's angel rounds. He said the grievances go to Social Services and documented on the grievance log. The NHA said the grievance is communicated to the designated department. He said the department that was assigned the grievance is responsible for the resolution. The NHA said the expectation was to return the resolved grievance to social services. He said the social services staff goes to the resident to let them know about the outcome and that the grievance was resolved. He stated for resident council he was, Still learning that process. He said there was a new activities director, and it has been a challenge. He said resident council meeting minutes/concerns are discussed with the interdisciplinary team (IDT) and the team decides to document as an individual grievance or as a whole for the resident council group. He said the food committee meetings started (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	about two months to help separate food concerns from resident council meetings. He said the activities staff handwrites the resident council minutes, then the resident council minutes are discussed with IDT team before they are typed up. Regarding concerns voiced in resident council and food committee meetings, the NHA stated, It's been a challenge and lack of follow through.A review of the facility's policy titled Complaint/Grievance, revised 10/24/22, revealed the following, Policy: The Center will support each resident's right to voice a complaint/grievance without fear of discrimination or reprisal. 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. The resident should have reasonable expectations of care and services and the center should address those expectations in a timely, reasonable, and consistent manner. The Center will inform residents of the right to file a grievance orally and in writing, the right to file grievances anonymously, the contact information of the Grievance Officer, a reasonable time frame for completing the review of the grievance, the right to obtain a written decision regarding the grievance, and contact information of independent entities with whom grievances may be file (State agency, Ombudsman, Quality Improvement Organizations). Further review of the policy, under procedure, revealed the following, 1. An employee receiving a complaint/grievance from a resident, family member and/or visitor will initiate a Complaint/Grievance Form. 2. Original grievance forms are then submitted to the Grievance Officer / designee for further 3. 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 4. The grievance follow-up should be completed in a reasonable time frame; this should not exceed 14 days. 5. The findings of the grievance shall be recorded on the Complaint/Grievance Form. 6. The results will be forwarded to the Executive Director for review and filing. 7. The Grievance Official will log complaints/grievances in Monthly Grievance Log. 8. The individual voicing the grievance will receive follow up communication with the resolution, a copy of the grievance resolution will be provided to the resident upon request.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations and interviews, the facility failed to ensure Activities of Daily Living (ADL) were provided to maintain grooming and personal hygiene for one (#19) resident of one resident reviewed for ADL care. Findings include:On 4/13/2026 at 3:38 PM an observation was made of Resident #19 sitting in their wheelchair with a blanket pulled over their head/face. The resident was wearing sweatpants that were soaked through from the briefs being overly wet and not changed from the 7-3 shift or the start of the 3-11 shift. In Resident #19's lap area were paper towels soaked in a yellow body fluid. Resident #19 was unable to communicate their needs.A review of Resident #19's admission record revealed an admission date of 4/10/2024 with diagnoses to include unspecified dementia, cognitive communication deficit, need for assistance with personal care, persistent mood (affective) disorder, anxiety disorder, and stage 3 chronic kidney disease.A review of Resident #19's Quarterly Minimum Data Set (MDS) assessment, dated 3/25/26, in section C - cognitive patterns revealed a Brief Interview Mental Score (BIMS) of 99, indicating Resident #19 has severe cognitive impairment. In Section GG- Functional Abilities revealed that Resident #19 scored a 1, Dependent-Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. Resident #19 for toilet transfer scored a 88-Not attempted due to medical condition or safety concerns. In Section H-Bladder and Bowel scored a 3-Always incontinent for both bladder and bowel continence. A review of Resident #19's progress notes dated 3/30/26-4/13/26 revealed the following the resident is alert with confusion and is dependent for most ADLs related to decreased cognitive function and decreased mobility. The resident is incontinent of bowel and bladder and wears briefs that are changed by staff as needed. Nursing reported Resident #19 has been cooperative with caregiving and taking his medications without reported side effects.A review of Resident #19?s Care Plan revealed the resident is at risk for decreased ability to perform ADL in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion and toileting related to cognitive and physical decline. Further review revealed Resident #19 has a communication problem due to a brain injury, cognitive impairment, expressive aphasia, and receptive aphasia, with interventions to include: Anticipating and meeting the resident's needs per physical/non-verbal indications of discomfort/distress and follow up as needed. Resident #19's care plan revealed the resident has bowel incontinence with interventions to include to check on the resident routinely/frequently and assist with toileting as needed.On 4/13/2026 at 3:39 PM an interview was conducted with Staff P, Certified Nursing Assistant (CNA) for Resident #19. This aide was observed at the nurses station conversing with fellow care staff. The CNA was unaware of Resident #19's condition due to admitting she did not do her initial rounds by going into each room and checking on the residents as of yet. The CNA stated she had not completed her rounds when she clocked in, even though she is supposed to do rounds the moment she clocks in. Staff P, CNA stated prior shift must not have changed the resident either, nor did they make her aware of Resident #19 needing to be changed.On 4/13/2026 at 3:41 PM an interview was conducted with Staff Q, Licensed Practical Nurse (LPN), for Resident #19. Staff Q, LPN stated the CNAs are supposed to do bed side rounds at the start of the shift to ensure that all residents have water and are changed as needed. When asked if Staff Q, LPN was aware of the condition of the resident at the start of her shift, she stated she was unaware at the time. Staff Q, LPN stated they speak to mostly everybody when they start their shift. With Resident #19 being left in a soaked brief, Staff Q, LPN said it means the 7-3 CNA did not check on the resident all day, and that they have had these same issues with that CNA before as this was not the first time this has happened with this CNA.On 4/13/2026 at 3:44 PM an interview was conducted with the Director of Nursing (DON). The DON stated the CNAs should be checking on residents who are incontinent at least every 2-hours and more frequent for those residents who are unable to communicate. The DON stated Resident #19 should have been changed by now, even if the 7-3 shift CNA did not change the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident, the 3-11 shift CNA should have completed the task at start of their shift.A review of the facility's Diarrhea and Fecal Incontinence policy revealed the following: Residents must be cleaned after each episode of incontinence.A Bladder Incontinence and/or ADL Policy was requested from the facility, but was not provided by the facility.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interviews, and record reviews, the facility failed to ensure respiratory care and services that is in accordance with professional standards of practice were provided related to: 1. ensuring oxygen was administered per physician orders for one resident (#10) out of two reviewed for oxygen therapy; 2. Failed to provide tracheostomy care according to professional standards of practice for two residents (#10, #12) out of two residents reviewed for tracheostomy care.Findings included:1.On 4/13/26 at 09:53 a.m., Resident #10 was observed in bed with a trach mask, delivering 2 liters per minute of oxygen at 28% humidity. There were red specks appearing to be dried blood in the trach mask. There were large amounts of tannish white secretions leaking out of trach mask onto a wash cloth which was under the trach mask. There was free water observed in lower portion of tubing prior to a water collection bag. The collection bag was placed on its side next to Resident #10 in bed. There were no dates on the oxygen tubing and trach tubing. Condensation was present on compressor and water was present on the table below equipment. [Photographic Evidence Obtained]On 4/13/26 at 10:58 a.m. and at 11:58 a.m., Resident #10 was observed in the room, there were no changes from prior observation. On 4/13/26 at 12:57 p.m., an interview and observation were conducted with Staff B, Registered Nurse (RN), at Resident #10's bedside. There were still no dates present on oxygen or trach tubing. Staff B, RN, reported that suction and care is given every shift and as needed, he stated The Resident [#10] has a lot of secretions and will need another suction before I leave. Staff B, RN, verified Resident #10 was receiving 2 liters per minute of oxygen at 28% humidity. Staff B, RN, reviewed the record and was unable to identify a physician order. Staff B, RN, stated, there should be an order. Staff B, RN, reported that trach suctioning and care would be charted in a progress note or in the treatment administration record (TAR). Staff B, RN, confirmed that all emergency trach supplies should be at the bedside to include trach tube, inner cannula, sterile catheters for suctioning, and an artificial manual breathing unit.An interview and observation were conducted on 4/13/26 at 2:35 p.m., Staff A, Licensed Practical Nurse (LPN) Unit Manager (UM), was unable to locate a trach tube in Resident #10's room and stated, We must have run out in here, but they are in central supply. Staff A, LPN, verified Resident #10 was on 2 liters per minute of 28% humidified oxygen. Staff A, LPN, confirmed oxygen is administered with a physician order. Staff A, LPN, was unable to locate a physician order for oxygen and humidity via trach mask in the orders for Resident #10. Review of Resident #10's admission record showed an admission date of 4/8/26 with a primary diagnosis of chronic respiratory failure with hypoxia. Other diagnoses included dysphagia, aphagia, unspecified dementia, and tracheostomy status. Review of Resident #10's orders on the Medication Administration Record (MAR), effective as of 4/13/26, included but was not limited to: Head of bed maintained 30 degrees or more; every shiftChange trach ties daily and PRN (as needed) if soiled; as neededSuction tracheostomy tube as needed to clear airway. Document results in PN (progress note); as neededObserve for changes in skin integrity of stoma site, i.e., redness, excoriation, signs/symptoms of infection during care; every shiftChange trach tubing and circuit tubing (label and date all tubing); every night shift every FridayTracheostomy site dressing change; every shift and as needed if soiledTrach: (Artificial manual breathing unit) bag and extra trach same size (6) and one size smaller (4) to be kept at bedside; every shiftReview of Resident #10's medical record revealed there was no order for humidified oxygen via trach mask.Review of Resident #10's Treatment Administration Record (TAR) from 4/8/26 to 4/13/26 revealed: Change trach ties daily and PRN if soiled every day shift; started 4/10/26: No entries for 4/10/26, 4/12/26, 4/13/26Change trach tubing and circuit tubing (label and date all tubing) every night shift every Friday; started 4/10/26: Charted 4/10/26Suction tracheostomy tube as needed to clear airway. Document results in PN as needed; started 4/9/26: No entries chartedTracheostomy site dressing change every shift: No entries charted on day shift 4/10/26, 4/12/26Review of Resident #10's care plan, initiated on 4/9/26, showed: Focus: exhibits or is at risk for respiratory complications related to dx (diagnosis) of: (continued on next page)

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	105394	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at the Palms	2600 Highlands Blvd N Palm Harbor, FL 34684

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Tracheostomy. Goal: will be free of s/s (signs/symptoms) of respiratory distress, and maintain optimal functioning within limitations imposed by disease process through review date. Interventions include but not limited to administer oxygen as ordered (Refer to MAR for current order).2. On 4/13/26 12:20 p.m. Resident #12 was observed in bed with tracheostomy mask delivering 5 liters per minute of oxygen at 28% humidity. Trach and oxygen tubing were not dated. A bag hung from side table was dated 3/28/26. There was no drainage observed at trach site or in the trach mask. The replacement trach tube was not readily accessible during observation. On 4/13/26 at 3:45 p.m. an observation and interview were conducted. Resident #12 was observed in bed with clear to white drainage at the trach site. Staff D, LPN, stated, Dates on the tubing are a night shift responsibility. Staff D, LPN, verified there were no dates on Resident #12's oxygen and trach tubing and pointed to a bag with a date of 3/28/26. Staff D, LPN, confirmed the expectation that emergency supplies should be at the bedside. Staff D, LPN, was unable to locate the trach tube at the bedside and stated, The trach tube is kept in central supply.Review of Resident #12's admission records showed an admission date of 3/26/26 with a primary diagnosis of acute and chronic respiratory failure with hypoxia and additional diagnoses to include anoxic brain damage, other specified chronic obstructive pulmonary disease, dysphagia, tracheostomy status, and dependence on supplemental oxygen. Review of Resident #12's TAR for 4/1/26 to 4/13/26 revealed:- Change O2 (oxygen) tubing (label and dating tubing) and bag cover every week every night shift every Sunday for maintenance - start date 3/29/26- Oxygen @ 5 liters per minute via trach mask with 28% humidified air continuously every shift for Acute on Chronic Hypoxic Respiratory Failure - start date 3/27/26Review of Resident #12's medical record revealed there were no orders or treatments for trach tubing, care, suctioning, and emergency supplies at the bedside Review of Resident #12's care plan, initiated on 3/27/26, showed: Focus: has a tracheostomy and is at risk for complications related to artificial airway device. Goal: will maintain effective airway through the next review date. Interventions include suction resident as needed and trach care every shift and PRN.On 4/13/26 at 2:35 p.m. an interview was conducted. Staff A, LPN, stated Trach care and suction should be provided every shift and as needed. Staff A, LPN, confirmed expectations that trach tubing and oxygen tubing were to be dated when changed. Staff A, LPN, confirmed expectations that all emergency trach supplies be at the bedside to include a trach tube. Staff A, LPN, stated trach care, suctioning, and drainage amount be charted in a progress note or treatment administration record. On 4/13/26 at 2:55 p.m., an interview was conducted. The Director of Nursing (DON) stated, the expectation is that clinical staff are following a physician order for tracheostomy care and the orders are specific to each resident. The DON confirmed a physician order was required for a resident on oxygen therapy. The DON confirmed all trach care performed by the nursing staff should be documented in the medical record. Review of a facility policy titled, Tracheostomy Care Policy, document RT-525, effective 11/30/2014, revised 1/29/2026 revealed, Tracheostomy care is a skilled respiratory therapy intervention performed to maintain airway patency, prevent infection, ensure proper function of the tracheostomy tube, and promote resident safety and comfort. All tracheostomy care, including the cleaning of reusable inner cannulas and stoma care, shall be performed only with a physician or authorized provider order and in accordance with the resident's individualized plan of care.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure nursing staff had the appropriate competencies related to intravenous (IV) therapy for two residents (#20, #21) of three sampled for IV therapy and failed to ensure tracheostomy care was completed competently for two residents (#10, #12) of two sampled residents.Cross reference F695Findings included:Review of an employee list of IV certifications, provided by Human Resources (HR), showed 15 out of 19 LPNs with IV certification expired on [DATE].Interview on [DATE] at 6:55 p.m. Human Resources (HR) stated, The person before me may have had a list of all the LPN certifications, however I was only able to verify the IV therapy certifications that I could put my eyes on for four LPNs on the list I gave you. HR stated, The list includes all the licensed practical nurses, and I entered [DATE] as an expiration date because I don't have documentation of their IV therapy certification.During an interview on [DATE] at 7:01 p.m., the Director of Nursing (DON) stated, The previous DON did an audit to confirm (IV therapy) certification, but I don't have access to it. The DON confirmed that the HR Department tracks and audits IV therapy certifications for the LPNs. The DON confirmed that the expectation was for LPNs to have IV therapy certification. During an interview on [DATE] at 4:58 p.m., Staff A, LPN, stated, Only a few LPNs don't have IV certification, and I will be assisting with the skills checkoffs. Staff A, LPN, stated, I am not sure why they don't have my IV certification.During an interview on [DATE] at 6:50 p.m., Staff C, LPN stated, I am IV certified. If I wasn't certified, I would have to get a certified LPN or RN.During an interview on [DATE] at 6:52 p.m., Staff D, LPN stated, I am IV certified. Staff D, LPN confirmed that if she was not certified she would need to get a certified licensed practical nurse or registered nurse to perform IV therapy.Review of the HR employee list, Staff C, LPN, and Staff D, LPN are listed with expired IV therapy certifications as of [DATE].1.Review of Resident's #20 admission record showed an admission date of [DATE] with a primary diagnosis of unspecified cerebral palsy and additional diagnosis included left hand other acute osteomyelitis.Review of Resident's #20 Medication Administration Record (MAR) from [DATE] to [DATE] revealed:-Cefazolin (antibiotic) sodium injection (started [DATE]): 2 grams intravenously (IV) every 8 hours: 24 out of 35 opportunities charted by Licensed Practice Nurse (LPN) (Staff F, G, H, I, J, K) without facility documentation of IV competency.-Heparin lock flush solution 10u/mL use 5mL intravenously every 8 hours for flush of lumens after med admin; flush with 10mL of normal saline before med; flush with 10mL of normal saline after med; followed by heparin: 24 out of 35 opportunities administered by LPN (Staff F, G, H, I, J, K) with no documentation of IV competency.2. Review of Resident #21's admission record showed an admission date of [DATE] with a primary diagnosis of quadriplegia, C1-C4 incomplete and additional diagnoses included unspecified local infection of the skin and subcutaneous tissue, unspecified organism sepsis, carrier or suspected carrier of methicillin resistant staphylococcus aureus, and personal history of urinary (tract) infections.Review of Resident #21's MAR from [DATE] to [DATE] revealed:-Cefepime (antibiotic) HCL Intravenous Solution Reconstituted 2 grams (Effective [DATE] to [DATE]): Use 2 grams intravenously every 8 hours for infection: 8/10 opportunities administered by LPN (Staff F, H, K) with no documentation of IV competency.3. 1.On [DATE] at 09:53 a.m., Resident #10 was observed in bed with a trach mask, delivering 2 liters per minute of oxygen at 28% humidity. There were red specks appearing to be dried blood in the trach mask. There were large amounts of tannish white secretions leaking out of trach mask onto a wash cloth which was under the trach mask. There was free water observed in lower portion of tubing prior to a water collection bag. The collection bag was placed on its side next to Resident #10 in bed. There were no dates on the oxygen tubing and trach tubing. Condensation was present on compressor and water was present on the table below equipment. [Photographic Evidence Obtained]On [DATE] at 10:58 a.m. and at 11:58 a.m., Resident #10 was observed in the room, there (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were no changes from prior observation.On [DATE] at 12:57 p.m., an interview and observation were conducted with Staff B, Registered Nurse (RN), at Resident #10's bedside. There were still no dates present on oxygen or trach tubing. Staff B, RN, reported that suction and care is given every shift and as needed, he stated The Resident [#10] has a lot of secretions and will need another suction before I leave. Staff B, RN, verified Resident #10 was receiving 2 liters per minute of oxygen at 28% humidity. Staff B, RN, reviewed the record and was unable to identify a physician order. Staff B, RN, stated, there should be an order. Staff B, RN, reported that trach suctioning and care would be charted in a progress note or in the treatment administration record (TAR). Staff B, RN, confirmed that all emergency trach supplies should be at the bedside to include trach tube, inner cannula, sterile catheters for suctioning, and an artificial manual breathing unit.An interview and observation were conducted on [DATE] at 2:35 p.m., Staff A, Licensed Practical Nurse (LPN) Unit Manager (UM), was unable to locate a trach tube in Resident #10's room and stated, We must have run out in here, but they are in central supply. Staff A, LPN, verified Resident #10 was on 2 liters per minute of 28% humidified oxygen. Staff A, LPN, confirmed oxygen is administered with a physician order. Staff A, LPN, was unable to locate a physician order for oxygen and humidity via trach mask in the orders for Resident #10.Review of Resident #10's admission record showed an admission date of [DATE] with a primary diagnosis of chronic respiratory failure with hypoxia. Other diagnoses included dysphagia, aphagia, unspecified dementia, and tracheostomy status.Review of Resident #10's orders on the Medication Administration Record (MAR), effective as of [DATE], included but was not limited to:Head of bed maintained 30 degrees or more; every shiftChange trach ties daily and PRN (as needed) if soiled; as neededSuction tracheostomy tube as needed to clear airway. Document results in PN (progress note); as neededObserve for changes in skin integrity of stoma site, i.e., redness, excoriation, signs/symptoms of infection during care; every shiftChange trach tubing and circuit tubing (label and date all tubing); every night shift every FridayTracheostomy site dressing change; every shift and as needed if soiledTrach: (Artificial manual breathing unit) bag and extra trach same size (6) and one size smaller (4) to be kept at bedside; every shiftReview of Resident #10's medical record revealed there was no order for humidified oxygen via trach mask.Review of Resident #10's Treatment Administration Record (TAR) from [DATE] to [DATE] revealed:Change trach ties daily and PRN if soiled every day shift; started [DATE]: No entries for [DATE], [DATE], [DATE]Change trach tubing and circuit tubing (label and date all tubing) every night shift every Friday; started [DATE]: Charted [DATE]Suction tracheostomy tube as needed to clear airway. Document results in PN as needed; started [DATE]: No entries chartedTracheostomy site dressing change every shift: No entries charted on day shift [DATE], [DATE]Review of Resident #10's care plan, initiated on [DATE], showed: Focus: exhibits or is at risk for respiratory complications related to dx (diagnosis) of: Tracheostomy. Goal: will be free of s/s (signs/symptoms) of respiratory distress, and maintain optimal functioning within limitations imposed by disease process through review date. Interventions include but not limited to administer oxygen as ordered (Refer to MAR for current order).4. 2. On [DATE] 12:20 p.m. Resident #12 was observed in bed with tracheostomy mask delivering 5 liters per minute of oxygen at 28% humidity. Trach and oxygen tubing were not dated. A bag hung from side table was dated [DATE]. There was no drainage observed at trach site or in the trach mask. The replacement trach tube was not readily accessible during observation. On [DATE] at 3:45 p.m. an observation and interview were conducted. Resident #12 was observed in bed with clear to white drainage at the trach site. Staff D, LPN, stated, Dates on the tubing are a night shift responsibility. Staff D, LPN, verified there were no dates on Resident #12's oxygen and trach tubing and pointed to a bag with a date of [DATE]. Staff D, LPN, confirmed the expectation that emergency supplies should be at the bedside. Staff D, LPN, was unable to locate the trach tube at the bedside and stated, The trach tube is kept in central supply.Review of Resident #12's admission records showed an admission date of [DATE] with a primary diagnosis of acute and chronic respiratory failure with hypoxia and additional diagnoses to include anoxic brain damage, other specified chronic obstructive pulmonary (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disease, dysphagia, tracheostomy status, and dependence on supplemental oxygen.Review of Resident #12's TAR for [DATE] to [DATE] revealed:- Change O2 (oxygen) tubing (label and dating tubing) and bag cover every week every night shift every Sunday for maintenance - start date [DATE]- Oxygen @ 5 liters per minute via trach mask with 28% humidified air continuously every shift for Acute on Chronic Hypoxic Respiratory Failure - start date [DATE]Review of Resident #12's medical record revealed there were no orders or treatments for trach tubing, care, suctioning, and emergency supplies at the bedsideReview of Resident #12's care plan, initiated on [DATE], showed: Focus: has a tracheostomy and is at risk for complications related to artificial airway device. Goal: will maintain effective airway through the next review date. Interventions include suction resident as needed and trach care every shift and PRN.On [DATE] at 2:35 p.m. an interview was conducted. Staff A, LPN, stated Trach care and suction should be provided every shift and as needed. Staff A, LPN, confirmed expectations that trach tubing and oxygen tubing were to be dated when changed. Staff A, LPN, confirmed expectations that all emergency trach supplies be at the bedside to include a trach tube. Staff A, LPN, stated trach care, suctioning, and drainage amount be charted in a progress note or treatment administration record.On [DATE] at 2:55 p.m., an interview was conducted. The Director of Nursing (DON) stated, the expectation is that clinical staff are following a physician order for tracheostomy care and the orders are specific to each resident. The DON confirmed a physician order was required for a resident on oxygen therapy. The DON confirmed all trach care performed by the nursing staff should be documented in the medical record.Interview on [DATE] at 2:45 p.m. with the HR personnel revealed, I don't have that in reference to documentation for nursing competency assessments for tracheostomy care and suctioning.Interview on [DATE] at 2:55 p.m. with DON confirmed the expectation of documented nursing assessments showing competency for tracheostomy care and suctioning. The DON stated, I have only been here for a couple weeks, but I am working on the staff competencies.On [DATE] at 3:17 p.m., the DON failed to provide a list of documented competencies for tracheostomy care and suctioning for nursing staff as requested.Review of a facility policy titled, Tracheostomy Care Policy, document RT-525, effective [DATE], revised [DATE] revealed, Tracheostomy care is a skilled respiratory therapy intervention performed to maintain airway patency, prevent infection, ensure proper function of the tracheostomy tube, and promote resident safety and comfort. All tracheostomy care, including the cleaning of reusable inner cannulas and stoma care, shall be performed only with a physician or authorized provider order and in accordance with the resident's individualized plan of care.The facility did not provide IV therapy policy.