STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105416	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Beneva	741 South Beneva Road Sarasota, FL 34232

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility's policies and procedures, staff and resident interviews, the facility failed to protect residents' rights to be free from neglect by failing to follow physician medication orders for 2 (Resident #875 and #775) of 4 residents reviewed. The facility failed to perform and document weekly skin evaluations for 1 (Resident #99) of 3 sampled residents at risk for pressure ulcer to ensure timely identification and treatment of skin alterations. The findings included: Review of the facility policy N-1265 Abuse, Neglect, Exploitation and Misappropriation, documented It is inherent in the nature and dignity of each resident at the center that he or she be afforded basic human rights including the right to be free from abuse, and neglect, mistreatment. Employees of the center are charged with a continuing obligation to treat residents, so they are free from abuse, neglect, and mistreatment.The facility defines neglect as the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include but are not limited to: Failure to take precautionary measures to protect the health and safety of the resident. Intentional lack of attention to physical needs. Failure to provide services that result in harm to the resident, such as not turning a bedfast resident or leaving a resident in a soiled bed. 1. Review of the clinical record revealed Resident #875 was an alert and oriented [AGE] year old female admitted to the facility on [DATE] at 4:30 p.m. Diagnoses included convulsions, neuropathy, peripheral vascular disease, type 2 diabetes mellitus, hypertension, discitis and osteomyelitis to lumbar spine.Review of Resident #875's physician orders revealed an order to administer Carbamazepine 200 milligrams, 3 tablets at bedtime for seizures.Review of the Medication Administration Record (MAR) lacked documentation the medication was administered on 6/12/25. Review of the facility's provided investigation for neglect revealed documentation that Resident #875 was admitted to the facility on [DATE] around 4:00 p.m. On 6/13/25 it was discovered that the assigned nurse, Licensed practical nurse (LPN) Staff D failed to activate the medication orders that were in the computer system. The failure to activate the medication orders resulted in the pharmacy not being aware of the new admission and the medication orders that needed to be filled and delivered. The nurses on the following shift were able to obtain some of the resident's medications from the facility emergency medication supply. Carbamazepine 200 milligrams give 3 tablets at bedtime for seizures was not available and was not administered on 6/12/25.Review of the Employee Corrective Action Form dated 6/17/25 for LPN Staff D documented On 6/12/25 employee did not activate the medication orders for a new admission. Employee did not obtain signatures for consent forms that are necessary to be able to treat patient. Employee failed to complete the nursing admissions assessments and due to the employee's negligence, the patient did not receive her medications timely. The employee was terminated.The facility did not substantiate the allegation of neglect.On 6/16/25, 3 days after admission, Resident #875 requested to be discharged . On 8/11/25 at 3:25 p.m., in a telephone interview, Resident #875 said, I did not get all of my medications when I arrived there. I did not get my Carbamazepine. I take 3 tablets at bedtime for seizures. I was tearful and afraid. It is so important that I get that. I don't know why they did not have my medicine when I got there. I was only there 3 days, and I was ready to leave day 1. I was upset, I was crying. I did throw a fit because I needed my seizure medication. I had just come from a long hospital stay and I did not want to go back. The facility never told me why they did not have my medication.On 8/12/25 at 8:25 a.m., in an interview the Regional Nurse Consultant (RNC) said Resident #875 did not get the Carbamazepine on 6/12/25 because the nurse did not complete the admission. She said, We did education and the nurse (LPN Staff D) was terminated. On 8/13/2025 at 2:10 p.m., in an interview the Director of Clinical Services (DCS) was asked about the facility's process for ordering medications to ensure new admissions received their ordered medications in a timely manner. The DCS said it should be done within 24 hours. When asked about the timeframe requirement for a nurse to complete the medication orders, he said, It depends on what it is going on throughout the day and how many medications the resident is on. When asked how the pharmacy receives the orders for medications, he said Once they are in the electronic system they are activated immediately. As soon as you put in the orders, it's activated and in. Pharmacy gets the notification at that time. When asked to clarify activation, he said, When orders are put in the system, they go into a queue. It shows up as red. The nurse reviews and verifies the orders then hits activate the order which goes to pharmacy. The DCS demonstrated the process of entering, queuing, and activating the orders in the system. The DCS said if the medications

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility's policies and procedures, staff and resident interviews, the facility failed to ensure staff consistently performed weekly skin evaluations for 1 (Resident #99) of 3 residents reviewed for early identification and treatment of pressure ulcers. The findings included:Review of the facility provided weekly wound reports for pressure injury revealed documentation on 2/21/25 Resident #99 had a facility acquired pressure ulcer to the sacrum that measured 3.5 centimeters (cm) in length by 3.5 cm in width.On 8/7/25 the weekly wound report noted Resident #99 had a facility acquired stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle) on the sacrum measuring 2 cm x's 1.8 cm with 0.8 cm depth. A left hip facility acquired stage 4 pressure ulcer identified on 5/22/25 measured 2.5 cm x's 2.5 cm with 1.5 cm depth.Review of the facility provided incident investigation for Resident #99's facility acquired pressure ulcer revealed on 2/21/25 a nurse reported an open area over Resident #99's sacrum. The Director of Clinical Services (DCS) assessed the wound, and it was deemed unstageable. The incident investigation documented the 2 Certified Nursing Assistants (CNAs) who took care of Resident #99 on 2/15/25 said the resident had redness over the area and on 2/17/25 the area opened a little. Tissue injury may have been present under the skin but was not noted until it opened. The investigation noted on 9/19/24 the wound care physician identified a deep tissue injury to Resident #99's sacral area that healed. At some point between 12/17/24 and 2/21/25 the deep tissue injury re-developed and later became a pressure ulcer. The resident has several co-morbidities and healing of any wound is compromised by her diagnoses of peripheral vascular disease, Raynaud's disease and CREST syndrome (autoimmune disease that causes the skin and connective tissues to harden and tighten).The facility's investigation noted that Resident #99 returned to the facility on [DATE]. The hospital form 3008 noted that the resident had no wound over the sacrum. There was no record of a facility admission skin assessment or subsequent skin assessments. These should have been done weekly per facility policy.The summary of relevant resident record review noted that review of the Treatment Administration Record revealed two nurses documented that they performed skin assessments when in fact they were not done.The facility verified the allegation of neglect and documented, The two nurses involved did not perform the weekly skin assessment and is dereliction of duty. Furthermore, they documented on the Treatment Administration Record that the skin assessment was done but they did not do them. There is no record of skin assessments.On 8/11/25, Review of the clinical record for Resident #99 revealed an admission date of 7/26/24. Diagnoses included peripheral vascular disease, protein calorie malnutrition, left below knee amputation, major depressive disorder and current cigarette smoker.Review of Minimum Data Set (MDS) assessments revealed on 12/17/24 Resident #99 had an unplanned discharge to an acute care hospital. Resident #99 returned to the facility on [DATE].Review of the Quarterly MDS assessment with a target date of 12/29/24 revealed Resident #99's cognitive skills for decision making were intact with a Brief Interview for Mental Status score of 15. The MDS noted the resident was at risk of developing pressure ulcers and had no unhealed pressure ulcer. Resident #99 was always incontinent of bladder or bowel.Review of the Treatment Administration Record (TAR) for January 2025 and February 2025 revealed Licensed Practical Nurse (LPN) Staff B documented she completed the weekly skin sweeps on 1/6/25, 1/12/25, 1/19/25, 1/28/25, 2/2/25 and 2/16/25.LPN Staff A documented she completed the weekly skin sweeps on 2/9/25 and 2/23/25.Review of the Wound Care Physician (WCP) progress note dated 2/27/25 revealed Resident #99 had an unstageable pressure ulcer to the sacrum (Pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed) measuring 3.5 centimeters (cm) length by 3.5 cm width. The WCP ordered to cleanse with normal saline, apply Santyl (ointment to remove dead tissue) and cover with a dry dressing daily.On 8/11/25 at 10:12 a.m., Resident #99 was observed lying in bed on her left side. In an interview the resident said the nurse had just finished changing the dressings on her wounds. The resident said she was in pain from the wound care and had requested a pain pill. The resident rated her pain a 9 out of 10 (severe pain). Resident #99 said she requires help to turn in bed.On 8/11/25 at 10:23 a.m., in an interview with Registered Nurse (RN) Staff H said she was doing the wound care today. She said she was not the wound care nurse but when there was an extra person on the assignment, someone does the wound care. The RN Staff H said Resident #99 had 3 wounds. The sacrum and the left hip were treated with Moist Dakins solution (broad spectrum antiseptic) and dry sterile dressing daily and as needed. The Left hip was infected, and the resident was receiving the antibiotic Bactrim. RN Staff H said the