

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Aviata at Beneva		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review, residents and staff interviews, the facility failed to ensure 2 (Residents #900 and #800) of 3 dependent residents reviewed were treated with dignity by failing to respond timely to residents' call lights and failing to provide incontinent care to meet the residents' needs. The findings included: On 10/13/25, review of the facility's grievance log revealed residents' grievances for delays in responding to the call lights on 9/1/25, 9/4/25, 9/5/25, 9/16/25 and 9/24/25. On 9/24/25 a complaint/grievance form report documented, Delayed call light on overnight 11-7. On 10/13/25 at 10:42 a.m., in an interview Resident #900 said staff often do not answer the call light after 5:30 p.m. to 6:00 p.m. When they do, they turn it off, say they'll be back, but they don't. There has been time he had to sit in a soiled incontinent brief for 1 to 2 hours. Staff come in with an attitude when they have to provide care and say they were busy. The resident said staff get mad at him when he keeps pressing the call light to request assistance. They tell him, You are not the only one. He said he has fallen trying to take himself to the bathroom. Resident #900 said it was frustrating, upsetting and inhumane to sit in a soiled brief. Review of the clinical record revealed Resident #900 had an admission date of 9/9/25. Diagnoses included weakness, hemiparesis (weakness on one side of the body) and hemiplegia (paralysis of one side of the body) affecting the right side. Review of the admission Minimum Data Set (MDS) with an assessment reference date of 9/15/25 revealed Resident #900 was dependent for toileting, dressing and bathing and was always incontinent of bowel and bladder. The MDS noted the resident scored 13 on the Brief Interview for Mental Status, indicating of intact cognitive skills for daily decision. Review of the Certified Nursing Assistant (CNA) documentation for September 2025 through October 13, 2025, failed to reveal documentation of bladder and bowel incontinence care on 10/1/25 (morning shift), on 9/22/25, 9/30/25, 10/2/25, 10/7/25 (evening shift), on 9/26/25, and 9/30/25 (night shift). On 10/13/25 at 12:00 p.m., in an interview Resident #800 said staff take more than 45 minutes to answer her call light. She said, When I am wet, I get a feeling of irritation when they don't come and change me. When they do show up, they tell me We are behind. They just don't get to me to get me up or change me. Sometimes they just don't care. Review of the clinical record for Resident #800 revealed an Annual MDS with an assessment reference date of 8/1/25. The MDS noted Resident #800 scored 15 on the BIMS, indicating intact cognition. The resident was dependent on staff for incontinent care, personal hygiene and bathing. Review of the Care Plan with a revision date of 9/25/24 revealed Resident #800 had an activities of daily living (ADL) self-care performance deficit related to decreased mobility, chronic pain, lymphedema (swelling of arms or legs), and lower extremities weakness. The goal with a revision date of 5/8/25 noted the resident would receive appropriate staff support with ADL's/mobility. The care plan noted the resident was incontinent of bowel and bladder. Review of the CNA documentation for September 2025 through October 13, 2025, failed to reveal documentation of incontinent care on 9/20/25 (day shift), 9/1/25, 9/8/25, 9/18/25, 9/30/25 (evening shift), 9/6/25, 9/30/25, 10/9/25 (night shift). On 9/11/25, 9/12/25, 9/20/25, and 9/29/25, N/A was entered for the evening shift. On 9/10/25, N/A was entered for the night shift. On 10/13/25 at 3:17 p.m., in an interview related to answering call lights, CNA Staff G said I don't know what the expected time is to (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	answer a call light. If I'm in a room or if I go on break, I can't see if the light is on. I really don't know. On 10/14/25 at 9:19 a.m., an interview was held with the Administrator related to the failure of staff to respond timely to residents' call lights and the failure to provide incontinent care to meet the needs of the residents. The Administrator said the facility had no policy on call light response time or incontinent care. All staff can answer the call lights. If they are not able to assist the resident, they are to leave the call light on and find someone who can assist help. The Administrator said they held a Quality Assurance and Performance Improvement meeting on 9/18/25 to address call light response time. She said they were also auditing call light response. The expectation was to answer the call lights within 5 minutes. Review of the Ad Hoc (unplanned) Quality Assurance and Performance Improvement Meeting dated 9/18/25 revealed there had been an increase in Resident grievances related to call light response time within the past 2 weeks. During staff rounds call lights were not always within reach. Call lights should be answered as timely as possible preferably within 5 minutes. Review of the call light audits revealed on 9/23/25 from 1:00 p.m. to 2:30 p.m., the call light response was not within 10 minutes for 6 of 10 rooms. The observer conducting the audit documented the CNA was there, but no one answered in time. She wrote, I told CNA that they need to answer light faster. I told nurses when they hear the light if CNA not around for them to answer lights. On 9/26/25 the observer answered: No for Call light answered timely and call lights are within reach upon rounds for one room. The observer documented, . Action was taken for one room audited. CNA was told that her light was on for 10 min [minutes] and that was to [sic] long. She understood and did apologize. The Administrator did not provide audits conducted on the evening shift or the night shift.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, review of facility's policy and procedure, resident and staff interviews, the facility failed to report an allegation of physical abuse to the Agency for Health Care Administration within the specified timeframe for 1 (Resident #1) of 3 residents reviewed. The findings included: Review of the facility provided Abuse, Neglect, Exploitation & Misappropriation Policies and Procedures with an effective date of 11/30/2014 and a revision date of 11/16/2022 revealed, Any employee or contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse . to a resident, is obligated to report such information immediately but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse . to the Administrator and to other officials in accordance with State law . Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations . Review of the clinical record revealed Resident #1 had an admission date of 7/9/25 with diagnoses including Parkinson's Disease with dyskinesia (involuntary, uncontrolled muscle movements), and anxiety. Review of the Quarterly Minimum Data Set (MDS) assessment with an assessment reference date of 9/30/25 revealed Resident #1 scored a 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. Review of the Care Plan initiated on 10/1/25 for Alteration in Usual Functional Performance in Mobility/Transfer revealed Resident #1 required supervision or touching assist with 1 staff for bed to chair transfer and toilet transfers. On 10/13/25 at 10:55 a.m., in an interview Resident #1 said that the Certified Nursing Assistant (CNA) who was assigned to her the night of 10/5/25 hurt her arm while assisting her to the bathroom. She reported the incident to CNA Staff H on 10/6/25. On 10/13/25 at 12:16 p.m., in an interview the Assistant Director of Nursing (ADON) said on 10/6/25, Licensed Practical Nurse (LPN) Staff I reported to her that Resident #1 alleged during the night of 10/5/25 the CNA who was assigned to her hurt her arm while assisting her to the bathroom. The ADON said she reported the allegation to the Administrator on 10/6/25 at approximately 9:00 a.m., during morning meeting. On 10/13/25 at 12:31 p.m., in an interview LPN Staff I said on 10/6/25 she was doing rounds when CNA Staff H reported to her that Resident #1 said during the night shift of 10/5/25, CNA Staff J hurt her arm while assisting her to the bathroom. LPN Staff I said she immediately reported the allegation to the Director of Nursing (DON) on 10/6/25 at approximately 8:30 a.m. Review of the facility provided investigation revealed the resident informed the ADON that during the night shift, the CNA came into the room to answer the light. The Resident informed the CNA that she needed assistance with toileting. The CNA grabbed the resident by the right hand and pulled her up. The resident stated that the CNA pulled her arm hard and it hurts from the wrist to the shoulder. The investigation noted the incident occurred on 10/5/25 at 8:00 p.m., and staff became aware of the incident on 10/6/25 at 12:00 p.m. The incident investigation noted the Administrator was notified of the incident on 10/6/25 at 2:07 p.m. Review of the incident reporting history revealed that the allegation of abuse was not reported to the Agency for Health Care Administration within 2 hours after the allegation was made as required. The report was submitted to the Agency for Health Care Administration on 10/7/25 at 1:07 p.m. On 10/14/25 at 12:59 p.m., in an interview the Administrator said the allegation of physical abuse should have been reported to the Agency for Health Care Administration within 2 hours and it was not.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review, resident and staff interviews, the facility failed to provide assistance with showers as outlined in the resident's care plan and according to residents' preferences for 2 (Residents #900 and #800) of 3 dependent residents reviewed. The findings included: Review of the clinical record revealed Resident #900 had an admission date of 9/9/25. Diagnoses included weakness, hemiparesis (weakness on one side of the body) and hemiplegia (paralysis of one side of the body) affecting the right side. Review of the admission Minimum Data Set (MDS) with an assessment reference date of 9/15/25 revealed Resident #900 was dependent for toileting, dressing and bathing and was always incontinent of bowel and bladder. The MDS noted the resident scored 13 on the Brief Interview for Mental Status, indicating of intact cognitive skills for daily decision. On 10/13/25 at 10:42 a.m., in an interview Resident #900 said he doesn't get his scheduled showers on Wednesdays and Sundays. He has gone days, even weeks without a shower. When he asks for a shower, staff tell him they'll be back to shower him but they don't. The resident pointed to a sign on the wall that documented his showers were scheduled on Wednesday and Sunday during the 7:00 a.m. to 3:00 p.m., shift. Review of the Certified Nursing Assistant (CNA) documentation for September and October 2025 revealed Resident #900 was scheduled for showers on Thursday and Sunday during the 7:00 a.m. to 3:00 p.m., shift. On 9/11/25, 9/18/25, 9/25/25 and 9/28/25 on scheduled shower days, a bed bath was documented. On 9/16/25, 9/23/25 and 9/30/25 there was no documentation of care. On 10/5/25 and 10/9/25 on scheduled shower days, N/A (not applicable) was entered for shower. Review of the clinical record for Resident #800 revealed an Annual MDS with an assessment reference date of 8/1/25. The MDS noted Resident #800 scored 15 on the BIMS, indicating intact cognition. The resident was dependent on staff for incontinent care, personal hygiene and bathing. Review of the Care Plan with a revision date of 9/25/24 revealed Resident #800 had an activities of daily living (ADL) self-care performance deficit related to decreased mobility, chronic pain, lymphedema (swelling of arms or legs), and lower extremities weakness. The goal with a revision date of 5/8/25 noted the resident would receive appropriate staff support with ADL's (Activities of Daily Living). On 10/13/25 at 12:00 p.m., in an interview Resident #800 said she likes to shower and get her hair washed but has not received a shower in several weeks. Review of the CNA documentation for September 2025 and October 2025, revealed Resident #800's shower days were Mondays and Thursdays on the 7:00 a.m. to 3:00 p.m. shift. On 9/1/25, 9/4/25, 9/11/25, 9/15/25 and 10/9/25 the documentation showed Resident #800 received a bed bath. On 9/29/25, N/A was documented. On 10/14/25 at 12:04 p.m., in an interview the Administrator said the facility had no policy on ADL care or bathing. The staff are expected to follow the shower schedule. On 10/14/25 at approximately 12:35 p.m., in an interview CNA Staff F said There is shower list at the desk, and you follow it. The residents will let you if they want a shower.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, review of facility's policy and procedure and staff interview, the facility failed to ensure medications were kept locked in 1 (300 hall) of 4 medications carts observed when not in use and under direct supervision. The findings included: Review of the facility policy 1.0 Medication Dispensing System (no effective date) documented Medication carts are always to be locked when out of sight or unattended. On 10/13/25 at 10:23 a.m., during a tour of the facility the 300-hall medication cart was observed unlocked, and unattended and unsecured for approximately 4 minutes. Residents and staff were observed passing by the unlocked medication cart. On 10/13/25 at 10:27 a.m., Licensed Practical Nurse Staff A was observed coming around the corner. She said she went to gather supplies for a resident and verified she left the medication cart unlocked and unattended for several minutes.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observation, record review, staff interview and review of facility policy and procedure the facility failed to implement corrective actions to achieve and maintain compliance in previously cited deficiencies. The findings included: Review of the facility's policy titled, Quality Assurance Performance Improvement (QAPI) dated 11/30/14 (revised 10/24/22) documented The Center and organization has a comprehensive, data-driven Quality Assurance Performance Improvement that focuses on indicators of the outcomes of care and quality of life. The center's QAPI program is on-going comprehensive review of care and services provided to residents. The program is a coordinated effort among departments and services within the organization that involves Leadership working with input from Center staff, families and residents. The Center will collect and monitor data from different departments reflecting its performance. The Center will utilize performance indicator to how much does it cost you monthly and when you're making monthly and compare the two that's how realistic budget established goals comma identify opportunities for improvement comma and evaluate progress towards goals. During a recertification and follow-up survey conducted on 1/5/26 through 1/9/26 the facility failed to maintain ongoing compliance by failing to ensure 1 of 3 dependent residents reviewed were treated with dignity by failing to respond timely to residents' call lights and failing to provide incontinent care to meet the residents' needs and showers. Review of the facility Plan of Correction specified by 11/20/25 the Director of Nursing (DON) will have completed quality review of current resident's plan of care charting to ensure showers and incontinent care are documented. The facility conducted 9 audits from 12/1/25 through 12/22/25 indicating all Certified Nursing Assistant (CNA) ADL (Activities of Daily Living) documentation was completed with showers and incontinent care completed and documented. On 1/6/26 at 8:58 a.m., Resident #800 said I put the call light on and usually they change me sometimes they tell me I have to wait and I don't like to wait when I'm wet. A sign indicating her shower days were Monday and Thursday on the 7-3 shift was on the wall above the bed. Resident #800 said showers are not always given, I don't refuse them. When they come in and say they are going to give me a shower I just let them do it. Sometimes it takes a long time for them to come in to help when I use the call light, maybe 15 to 30 minutes, sometimes it's an hour. Review of the CNA documentation revealed # 800 did not receive scheduled showers on 11/6/25 and 11/27/25. She received a bed bath on 12/4/25, and 12/29/25. By 11/20/25 the Social Service Director will complete weekly visits to ensure Resident #800 is not affected by the deficiency. On 1/9/26 at 10:00 a.m., in an interview with the Social Service Director, she said she documented all her visits in a progress note but was unable to provide the notes. She said, I did one audit with the resident on 12/29/25. The rest were in bypassing. On 1/5/2026 at 10:39 a.m., Resident #89 said he is not being turned, and no one answers his call light. He said on the evening shift they do not come for 15 minutes to an hour, and they will turn the light off and leave without providing care. The facility also failed to implement a system to ensure 2 of 3 dependent residents received scheduled showers. The facility conducted 9 audits from 12/1/25 through 12/22/25 indicating all CNA ADL documentation was completed and showers were documented. Review of the CNA documentation for November 2025 revealed Resident #800 was scheduled for showers on Monday and Thursday on the 7-3 shift. On 11/6/25 and 11/27/25 she received a bed bath. Review of the December 2025 CNA documentation revealed on 12/4/25, and 12/29/25 she received a bed bath. A review of the Certified Nursing Assistant (CNA) documentation for November to December 2005 revealed a bed bath was provided to Resident #800 in place of the scheduled evening showers on Wednesday and Saturday on 11/22/25, 12/3/25, 12/10/25, and 12/13/25. There was no documentation of a shower on 12/27/25 and 12/31/25. On 1/5/2026 at 10:39 a.m., during an observation and interview Resident #89 was noted to have long fingernails extending 1/2 inch past the tip of the fingers with a brown substance under the nail beds. He said he does not like them that long because they cut into his left hand due to a (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contracture. He was able to open his fingers slightly to show this writer his pinky finger had started to cause irritation to the palm of his hand. He said he does not have a splint, and no one ever puts anything in his hand to prevent the pressure. He was unshaven with 3 days of facial hair growth. Resident #89 said he had a wound on the left buttocks he acquired while at the facility and had to have 2 surgeries to close the wound after an infection to the bone. On 1/7/26 at 10:00 a.m., in an interview CNA Staff H said he was assigned to Resident #89 today. He said he did not know about shaving, doing nail care or repositioning /turning and was not able to answer any questions regarding the resident's care needs. On 1/7/26 at 10:50 a.m., this writer showed Unit Manager Licensed Practical Nurse Staff T and Resident Liaison Staff B the condition of Resident #89's fingernails and facial hair growth. Unit Manager Staff T said he did not know when the CNAs were supposed to shave or cut fingernails. I think it is whenever the resident asks them to.		