STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105417	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at the Bay	2916 Habana Way Tampa, FL 33614

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records review the facility failed to protect the resident's right to be free from neglect related to elopement for one resident (#5) out of three residents reviewed for elopement risk. On 8/30/25 Resident #5 exited the facility at approximately 4:15 p.m., unnoticed by staff. Resident #5 had severely impaired cognition, ambulated independently, had wandering behaviors, and did not have an electronic monitoring device on. Resident #5 was able to get from the fourth floor to the first floor, access a stairwell door that should have been locked, and then exit the facility. Another resident observed Resident #5 walking around the west side of the building to the front parking lot and directed her back to the building. Staff did not know Resident #5 was off the fourth floor. This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and or death to Resident #5 and resulted in the determination of Immediate Jeopardy on 1/27/26. The findings of Immediate Jeopardy were determined to be corrected on 9/3/25.Findings included:Review of Resident #5's progress notes showed:8/30/25 4:46 p.m. Nursing Progress Note Resident alert with confusion noted exiting the side door. Resident escorted back into facility. No signs of pain or discomfort noted. Skin assessment completed. No skin alterations noted. Safety measures in place. Placed on 1:1. Psych services currently pending. [Electronic monitoring device] applied and functioning properly. Review of admission Records showed Resident #5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, unspecified psychosis not due to a substance or known physiological condition, other symptoms and signs involving cognitive functions and awareness, depression, and anxiety. Review of Resident #5's Quarterly Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, showed a Brief interview for Mental Status (BIMS) was unable to be completed due to her rarely/never being understood. Section GG, Functional Abilities, showed she could walk 150 feet with supervision or touching assistance. Section P, Restraints and Alarms, showed a wander/elopement alarm was not used. Review of Resident #5's physician orders showed:-Check for electronic monitoring device placement to LLE (left lower extremity) each shift for elopement. Started: 2/19/25 Ended: 5/28/25. Review of Resident #5's active care plan on 8/30/25 showed a focus area of elopement risk/wandering r/t [related to] dementia, initiated 5/2/25. Interventions included Monitor [electronic monitoring device] to RLL [right lower extremity] frequently for function, initiated 2/19/25 and Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate, initiated 2/19/25. Review of Resident #5's Elopement Risk Evaluations dated 2/1/25 and 5/29/25, identified she was an elopement risk. Review of Resident #5's Progress notes showed:-7/16/25 Primary Care Provider 30-day Follow-up Ambulatory, conversational, but with severely decreased orientation/insight into situation and circumstances.-7/21/25 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Aviata at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 2916 Habana Way Tampa, FL 33614	

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Psychiatry Provider Progress Note: Staff reports increase in agitation, refusing care and combativeness. Review of Symptoms: Anxiety: Irritability, Restless/feeling keyed up. Mania: Acts with potential for painful consequences, Expansive or irritable mood Aggravating factors: Being in the facility, ongoing medical problems and life stressors Physical Exam: Neurologic: Other: alert to self, confused at baseline. Psychiatric: Cooperative, appropriate mood and affect, other: decreased insight, engaged in conversation but unable to express herself clearly.-8/23/25 12:07 a.m. Skilled Note: Level of consciousness noted as oriented to person .Behavioral problem are wandering.-8/28/25 3:23 a.m. Skilled Note: Level of consciousness noted as oriented to person.Behavioral problems are hallucinations and wandering.-8/28/25 3:12 p.m. Standards of Care Note: Resident is alert to self only, with confusion noted Resident ambulates independently, full weight-bearing, with steady gait. Resident has a primary diagnoses ofdementia [sic]. Resident exhibits wandering behavior throughout the unit and requires frequent redirection for safety. Resident demonstrates episodes of verbal and physical aggression toward staff during provision of care. Review of Resident #5's physical therapy notes showed: -8/29/25 Ambulation: Gait Distance =275 feet with no assistive device. An interview was conducted on 1/27/26 at 2;24 p.m. with Staff Q, Registered Nurse (RN). She said she worked with Resident #5 on 8/30/25. She said Resident #5 typically wandered around the fourth floor and staff would reorient her to her room regularly, but she had never seen Resident #5 off the fourth floor. Staff Q said on 8/30/25 she saw the resident at change of shift then again in the hall a short time later. She said she redirected Resident #5 to her room then 10-15 minutes or so later the supervisor, Staff R, RN came on the unit and said Resident #5 had been outside. Staff Q said she had no idea how the resident got off the unit and outside. She said she did not recall Resident #5 having an electronic monitoring device on before this incident, but confirmed one was placed on her after she returned to the unit on 8/30/25. She said normally nurses do an Elopement Risk Assessment every three months, if the resident is determined to be at risk, the supervisor or DON is notified. She said the supervisor or DON will bring an electronic monitoring device to the nurse to put on the resident or they will put it on the resident. An interview was conducted on 1/27/26 at 3:00 p.m. with Staff R, RN. She confirmed she was the supervisor on duty on 8/30/25 when Resident #5 eloped. She said Resident #5 was always confused, but she had no idea how the resident got out of the facility, but ‘she didn't go far. Staff R said, we weren't able to figure out what door she went out. She said an alarm did go off downstairs and staff were trying to figure out why. She said you can kind of pinpoint the area the alarm was coming from. She said it was like on the backside of the building. She then said it was on the west side of the building. Staff R said when the alarm went off staff did not know why it was going off or if a resident went out the door, but they started looking. She said while staff were looking to see if a resident went outside, another resident (Resident #13) saw Resident #5 in the parking lot and brought her to the front of the building. Staff R said she went out front and helped get Resident #5 back in the building. She said Resident #5 did not have any injuries. Staff R said Resident #5 did not have an electronic monitoring device on because she usually just kind of stayed on the unit. It wasn't warranted for her to have one. She said the resident had an electronic monitoring device placed after the incident. An interview was conducted on 1/26/26 at 3:41 p.m. with Resident #13. He said a few months ago he was out in front of the facility on leave of absence. He said he saw a lady walking around from the west side of the building by the generators. He said he didn't know her, but she was in a hospital gown with a blanket wrapped around her. He said it looked like she knew where she was headed, but it didn't look right to him. He said he walked over to her, and she was confused so he got her to come sit on the bench in front of the building. He said when she sat on the bench a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Aviata at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 2916 Habana Way Tampa, FL 33614	

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	staff member saw them through the front door and came outside. He said that staff member knew who the lady was.Review of admission Records showed Resident #13 was admitted on [DATE]. Review of Resident #13's Annual MDS, Section C, Cognitive Patterns, showed a BIMS score of 13, indicating he was cognitively intact.An interview was conducted on 1/27/26 3:35 p.m. with Staff S, Licensed Practical Nurse (LPN). Staff S said he was working on the third floor on the day Resident #5 eloped (8/30/25). He said no alarm ever went off for the doors that he heard. Staff S said Resident #5 normally wandered around the unit but never really left.An interview was conducted on 1/27/26 at 5:09 p.m. with the Nursing Home Administrator (NHA) and Director of Nursing (DON). They said on 8/30/25 around 4:30 p.m. they received a call from the weekend supervisor letting them know Resident #5 had gotten out of the building but was back safely. They said Resident #13 had seen Resident #5 outside and directed her back to the building safely. They said the resident had been an elopement risk when she first came to the building in January 2025, but she declined and went out to the hospital in May. They said when she returned, she was not an elopement risk because she could not get out of bed. The DON said the Elopement Risk Assessment completed in May 2025 was incorrect because the nurse did it based on information prior to the resident going to the hospital. They said there were three residents in the elopement books on 8/30/25, but Resident #5 was not one of them. The DON said it wasn't until August that Resident #5 started walking good. She said the resident did not have an electronic monitoring device placed when she started walking again because she was not exit seeking. The NHA and DON reviewed Resident #5's care plan and confirmed she had been care planned for an electronic monitoring device from February through September 2025. They said during their investigation they could not determine how Resident #5 got downstairs or into the stairwell. They said they interviewed residents and staff and did not find anyone that saw Resident #5 on the elevator or that possibly rode the elevator down with her. The NHA said after getting downstairs Resident #5 somehow got into the stairwell which was only accessible from a locked door with a keypad code. They said from the stairwell there is an exit door to the outside and that is where the resident exited. The NHA said they knew she exited that door because the alarm was going off on that door, however she said the alarm was just a beeping sound that could only be heard in the stairwell or just outside of the stairwell doors . The NHA said the receptionist in the front did not hear the alarm from down the hall. The NHA and DON said the staff did not know Resident #5 had gotten downstairs and outside until Resident #13 brought her to the front of the building and the receptionist saw them. They said she had not gone missing and there was no elopement code called. They said they did do an elopement drill that evening after the incident. The NHA confirmed that Resident #5 was not observed exiting the facility and Resident #13 was the only person to see the resident outside. She said Resident #13 found Resident #5 and brought her back to the facility. A follow-up interview was conducted on 1/29/26 at 12:48 p.m. with the NHA. She stated that the electronic monitoring device is a nursing intervention and did not require a physician's order. She said they do typically put an order in the system to ensure the electronic monitoring device is checked daily by staff. An interview was conducted on 1/28/26 at 12:42 p.m. with Staff T, Occupational Therapist (OT). Staff F said Resident #5 was in the late stages of dementia and had trouble sequencing tasks. He said she would wander the halls and constantly went into other residents' rooms. Staff T said Resident #5 might go towards the elevators to get on, but she was easily redirected. He said she did follow other residents where they were going. Staff T said Resident #5 would have had the strength to open doors, but he didn't feel like she could have walked down four flights of stairs without falling. He said Resident #5 was alert and oriented to person only. Staff T said he didn't feel like staff are educated enough on treatment of dementia residents. An interview (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Aviata at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 2916 Habana Way Tampa, FL 33614	

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	was conducted on 1/28/26 at 2:44 p.m. with Resident #5's Psychiatric-Mental Health Nurse Practitioner (PMHNP). She said Resident #5 was only oriented to person and was not able to care for herself. She said she didn't necessarily think of the resident as exit seeking because she was on the fourth floor, but the resident might follow other people out. An interview was conducted on 1/28/26 at 3:39 p.m. with Resident #5's primary care Advanced Registered Nurse Practitioner (ARNP). The ARNP said Resident #5 roamed the hallways and was only oriented to person. She said the resident couldn't answer questions appropriately, could walk independently, and would not be able to take care of herself. She said cognitively she didn't think Resident #5 would know what to do to care for herself. The ARNP said she could see Resident #5 waiting and following someone on the elevator. She said Resident #5 was easily redirected. The ARNP said she was honestly not able to answer as to why Resident #5 didn't have an electronic monitoring device on. An interview was conducted on 1/28/26 at 2:58 p.m. with Resident #5's primary care provider (PCP). He said Resident #5 was ambulatory and definitely confused; I think from that point of view she was an elopement risk. The PCP said he did not feel that Resident #5 was capable of caring for herself outside the facility. An interview was conducted on 1/28/26 at 7:38 a.m. with the Resident Representative (RR) for Resident #5. The RR said Resident #5 did go out to the hospital and declined drastically in May but she bounced back quickly and was up and moving weeks later. The RR said she had been told by staff before that the resident tried to get out of the building, but she didn't know she ever did actually get out. The RR said she [Resident #5] was always trying to escape and was always wandering around. The RR said Resident #5 could get around good and would have been able to go down the stairs in August 2025. An interview was conducted on 1/28/26 at 12:01 p.m. with Resident Representative #2 for Resident #5. He said he was notified that the resident got out of the facility, but the facility really downplayed it. He said Resident #5 was free to do whatever she wanted here and staff didn't watch her. He said the resident had worked night shift throughout her life and would wander around all evening and night, going in and out or other resident rooms messing with their stuff and taking items. He said she was always wandering around, and he believed she was trying to get to the door/elevators to get out. He said staff told him multiple times that Resident #5 tried to get out. He said, I think she was doing it [trying to get to the doors and elevators] all the time. He said she was not watched or taken good care of. Review of a facility policy titled Abuse, Neglect, Exploitation & Misappropriation, revised 11/16/2022, showed:POLICY:It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse.Employees of the center are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment, and/or misappropriation of property.No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and/or misappropriation of property against any resident. Violation of this standard will subject employees to disciplinary action, including dismissal, provided herein.Definitions:Neglect is 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 provide adequate nutrition and fluids. Failure to take precautionary measures to protect the health and safety of the resident. Intentional lack of attention to physical needs including, but not limited to, toileting and bathing. Failure to provide services that (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105417	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at the Bay	2916 Habana Way Tampa, FL 33614

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	result in harm to the resident, such as not turning a bedfast resident or leaving a resident in a soiled bed. Failure or refusal to provide a service for the purpose of punishing or disciplining a resident, unless withholding of a service is being used as part of a documented integrated behavioral management program. Failure to notify a resident's legal representative in the event of a significant change in the resident's physical, mental or emotional condition that a prudent person would recognize. Failure to notify a resident's legal representative in the event of an incident involving the resident, such as failure to report a fall or conflict between residents that result in injury or possible injury. Failure to report observed or suspected abuse, neglect or misappropriation of resident property to the proper authorities. Failure to adequately supervise a resident known to wander from the facility without the staff knowledge. Review of a facility policy titled Missing Patient/Resident, revised 8/1/2020 showed:Overview:Staff will investigate cases of missing patient/resident and possible elopement. An elopement occurs when a patient/resident leaves the premises or a safe area without authorization and or any necessary supervision to do so, placing the patient at risk for harm or injury. Review of a facility policy titled Elopement/Wandering Risk Guideline, revised 8/1/2020, showed:Overview:To evaluate and identify patient/residents that are at risk for elopement and develop individualized interventions.Process:-Patient/Residents to be evaluated on admission, re-admission, 7 days post admission, quarterly, with a significant change in condition, and elopement event using the risk tool. -If a patient/resident is identified as being at risk complete an Elopement Risk Alert and obtain a photograph. -Initiate individualized interventions based on Patient/Residents' risk. -Document individualized interventions in the patient/resident Care Plan and Kardex [a quick reference document used by staff to provide care that contains essential resident information]. -If utilizing a wander monitoring system device check placement of the device every shift and functionality every day. -Maintain the Elopement Risk Alerts in an easily accessible location. -Complete routine elopement drills monthly and review in QAPI [Quality Assurance Performance Improvement] meeting. The facility's immediate actions to remove the Immediate Jeopardy included: Identified resident #5 was returned to facility on 8/30/2025 by Weekend Supervisor. On 8/30/2025 Resident #5 had a skin assessment, pain assessment, and change of condition completed with no negative findings. On 8/30/2025 Resident #5 Attending Physician was notified on 8/30/2025 and gave new orders for labs that resulted with ESBL [Extended-Spectrum Beta-Lactamase - a bacteria that produces enzymes resistant to most common antibiotics] in urine, new meds ordered 9/5/2025. Psych services was completed via telehealth visit was completed with resident no new orders received. On 8/30/2025 Resident #5 was placed on 1:1 and elopement assessment was completed placing a [electronic monitoring device] to her lower extremity. Resident remained on 1:1 until 9/12/25 On 8/30/2025 Weekend Supervisor completed [electronic monitoring device] function and placement for all current residents that are at risk for elopement with no negative findings. All residents' demographics were found in each resident elopement binder at nurse station, receptionist and therapy gym. On 8/30/2025 Resident #5 demographics and picture was added to the elopement binder by DON. On 8/30/2025 Door checks were completed by NHA to ensure all doors worked properly with no negative findings. On 8/30/2025 a 100% head count was completed by Weekend supervisor to ensure all residents were in facility with no negative findings. On 8/30/2025 100% of residents were re-assessed for elopement risk by DON and Designee. No new residents were identified. On 8/30/2025 an initial Elopement drill was complete on 8/30/2025 by NHA & Designee reviewed results and documented them on Elopement Drill QAPI [Quality Assurance Performance Improvement] Worksheet with no negative findings. On 8/30/2025 NHA and DON gathered witness statements from residents and staff. On 8/31/2025 DON notified DCF [Department of Children and Families] & police of allegation of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105417	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at the Bay	2916 Habana Way Tampa, FL 33614

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	neglect and they did not accept the case. On 9/2/2025 Resident #5 was seen by psych services. She was alert with confusion, denied any distress, or intent to harm herself or others with no injuries with no complaints from the event. On 9/12/2025 Identified resident #5 discharged to a memory care unit as planned with IDT [Interdisciplinary Team], Family and Medical Director On 8/30/2025 Door guard was placed at door by NHA to ensure no one was able to leave from facility until screamers were installed. On 8/31/2025-9/7/2025 Elopement drills were completed every day, 3 times a day randomly. On 9/8/2025-9/30 Elopement drills were completed 1 time a week on random days. Monthly Drills have been completed monthly from October 2025- Current on random shifts and days. Results have been reviewed with QAPI Team. On 9/3/2025 Screamers were shipped from manufacturing company verified by Maintenance Director On 9/23/2025 a contractor came to facility to install cameras and new secure care boxes. Maintenance Director completed door checks to ensure they are functioning properly. On 9/23/2025 IDT & Clinical Consultant met to discuss removal of Door Guard. All agree On 9/23/2025 Security company came to facility to access possible amber alarm system and they were installed 10/7/2025 Security cameras were set up in the facility with main station located in NHA office. On 8/30/2025, 9/12/2025, 9/19/2025, and 9/26/2025 IDT including Medical Director met to review ADHOC [for this specific purpose] /QAPI plan with no negative findings. Medical Director reviewed and recommended no changes. On 8/30/2025 Education was initiated via phone [telephone] and in person with 100% of staff to include contract employees related to abuse & neglect, missing persons policy, elopement policy that included care plans and KARDEX for those at risk for wandering/elopement, and staff response to door alarms by ED and Designee. Completed on 8/31/2025 On 8/30/2025 elopement drills were initiated for 100% of staff to include contracted employees by DON and Designee. Verification of the facility's removal plan was conducted by the survey team on 1/28 and 1/29/26. - Interviews were conducted with forty staff members, who worked across all shifts, including housekeeping, dietary, administrative/clerical, therapy, social services, CNA's, licensed nurses. The staff members were able to state that they had been trained and were knowledgeable about the new policies and procedures initiated by the facility. - A tour of the facility with the Director of Maintenance (DOM) and staff interviews confirmed alarms and cameras had been installed and were functioning - A review of in-service documentation revealed 100% of staff had acknowledged education and training related to abuse, neglect, and exploitation, resident supervision, elopement protocols, and following care plans. Based on verification of the facility's Immediate Jeopardy removal plan the immediate jeopardy was determined to be corrected on 9/3/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Aviata at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 2916 Habana Way Tampa, FL 33614	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records review the facility failed to provide supervision to prevent elopement for one resident (#5) out of three residents reviewed for elopement risk. On 8/30/25 Resident #5 exited the facility at approximately 4:15 p.m., unnoticed by staff. Resident #5 had severely impaired cognition, ambulated independently, had wandering behaviors, and did not have an electronic monitoring device on. Resident #5 was able to get from the fourth floor to the first floor, access a stairwell door that should have been locked, and then exit the facility. Another resident observed Resident #5 walking around the west side of the building to the front parking lot and directed her back to the building. Staff did not know Resident #5 was off the fourth floor. This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and or death to Resident #5 and resulted in the determination of Immediate Jeopardy on 1/27/26. The findings of Immediate Jeopardy were determined to be corrected on 9/3/25. Findings included: Review of Resident #5's progress notes showed:8/30/25 4:46 p.m. Nursing Progress Note Resident alert with confusion noted exiting the side door. Resident escorted back into facility. No signs of pain or discomfort noted. Skin assessment completed. No skin alterations noted. Safety measures in place. Placed on 1:1. Psych services currently pending. [Electronic monitoring device] applied and functioning properly. Review of admission Records showed Resident #5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, unspecified psychosis not due to a substance or known physiological condition, other symptoms and signs involving cognitive functions and awareness, depression, and anxiety. Review of Resident #5's Quarterly Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, showed a Brief interview for Mental Status (BIMS) was unable to be completed due to her rarely/never being understood. Section GG, Functional Abilities, showed she could walk 150 feet with supervision or touching assistance. Section P, Restraints and Alarms, showed a wander/elopement alarm was not used. Review of Resident #5's physician orders showed:-Check for electronic monitoring device placement to LLE (left lower extremity) each shift for elopement. Started: 2/19/25 Ended: 5/28/25. Review of Resident #5's active care plan on 8/30/25 showed a focus area of elopement risk/wandering r/t [related to] dementia, initiated 5/2/25. Interventions included Monitor [electronic monitoring device] to RLL [right lower extremity] frequently for function, initiated 2/19/25 and Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate, initiated 2/19/25. Review of Resident #5's Elopement Risk Evaluations dated 2/1/25 and 5/29/25, identified she was an elopement risk. Review of Resident #5's Progress notes showed:-7/16/25 Primary Care Provider 30-day Follow-up Ambulatory, conversational, but with severely decreased orientation/insight into situation and circumstances.-7/21/25 Psychiatry Provider Progress Note: Staff reports increase in agitation, refusing care and combativeness. Review of Symptoms: Anxiety: Irritability, Restless/feeling keyed up. Mania: Acts with potential for painful consequences, Expansive or irritable mood Aggravating factors: Being in the facility, ongoing medical problems and life stressors Physical Exam: Neurologic: Other: alert to self, confused at baseline. Psychiatric: Cooperative, appropriate mood and affect, other: decreased insight, engaged in conversation but unable to express herself clearly.-8/23/25 12:07 a.m. Skilled Note: Level of consciousness noted as oriented to person .Behavioral problem are wandering.-8/28/25 3:23 a.m. Skilled Note: Level of consciousness noted as oriented to person.Behavioral problems are hallucinations and wandering.-8/28/25 3:12 p.m. Standards (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER: Aviata at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE: 2916 Habana Way Tampa, FL 33614	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	of Care Note: Resident is alert to self only, with confusion noted Resident ambulates independently, full weight-bearing, with steady gait. Resident has a primary diagnoses ofdementia [sic]. Resident exhibits wandering behavior throughout the unit and requires frequent redirection for safety. Resident demonstrates episodes of verbal and physical aggression toward staff during provision of care.Review of Resident #5's physical therapy notes showed: -8/29/25 Ambulation: Gait Distance =275 feet with no assistive device.An interview was conducted on 1/27/26 at 2;24 p.m. with Staff Q, Registered Nurse (RN). She said she worked with Resident #5 on 8/30/25. She said Resident #5 typically wandered around the fourth floor and staff would reorient her to her room regularly, but she had never seen Resident #5 off the fourth floor. Staff Q said on 8/30/25 she saw the resident at change of shift then again in the hall a short time later. She said she redirected Resident #5 to her room then 10-15 minutes or so later the supervisor, Staff R, RN came on the unit and said Resident #5 had been outside. Staff Q said she had no idea how the resident got off the unit and outside. She said she did not recall Resident #5 having an electronic monitoring device on before this incident, but confirmed one was placed on her after she returned to the unit on 8/30/25. She said normally nurses do an Elopement Risk Assessment every three months, if the resident is determined to be at risk, the supervisor or DON is notified. She said the supervisor or DON will bring an electronic monitoring device to the nurse to put on the resident or they will put it on the resident. An interview was conducted on 1/27/26 at 3:00 p.m. with Staff R, RN. She confirmed she was the supervisor on duty on 8/30/25 when Resident #5 eloped. She said Resident #5 was always confused, but she had no idea how the resident got out of the facility, but ‘she didn't go far. Staff R said, we weren't able to figure out what door she went out. She said an alarm did go off downstairs and staff were trying to figure out why. She said you can kind of pinpoint the area the alarm was coming from. She said it was like on the backside of the building. She then said it was on the west side of the building. Staff R said when the alarm went off staff did not know why it was going off or if a resident went out the door, but they started looking. She said while staff were looking to see if a resident went outside, another resident (Resident #13) saw Resident #5 in the parking lot and brought her to the front of the building. Staff R said she went out front and helped get Resident #5 back in the building. She said Resident #5 did not have any injuries. Staff R said Resident #5 did not have an electronic monitoring device on because she usually just kind of stayed on the unit. It wasn't warranted for her to have one. She said the resident had an electronic monitoring device placed after the incident. An interview was conducted on 1/26/26 at 3:41 p.m. with Resident #13. He said a few months ago he was out in front of the facility on leave of absence. He said he saw a lady walking around from the west side of the building by the generators. He said he didn't know her, but she was in a hospital gown with a blanket wrapped around her. He said it looked like she knew where she was headed, but it didn't look right to him. He said he walked over to her, and she was confused so he got her to come sit on the bench in front of the building. He said when she sat on the bench a staff member saw them through the front door and came outside. He said that staff member knew who the lady was. Review of admission Records showed Resident #13 was admitted on [DATE]. Review of Resident #13's Annual MDS, Section C, Cognitive Patterns, showed a BIMS score of 13, indicating he was cognitively intact. An interview was conducted on 1/27/26 3:35 p.m. with Staff S, Licensed Practical Nurse (LPN). Staff S said he was working on the third floor on the day Resident #5 eloped (8/30/25). He said no alarm ever went off for the doors that he heard. Staff S said Resident #5 normally wandered around the unit but never really left. An interview was conducted on 1/27/26 at 5:09 p.m. with the Nursing Home Administrator (NHA) and Director of Nursing (DON). They said on 8/30/25 around 4:30 p.m. they received a call from the weekend (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Aviata at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 2916 Habana Way Tampa, FL 33614	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	supervisor letting them know Resident #5 had gotten out of the building but was back safely. They said Resident #13 had seen Resident #5 outside and directed her back to the building safely. They said the resident had been an elopement risk when she first came to the building in January 2025, but she declined and went out to the hospital in May. They said when she returned, she was not an elopement risk because she could not get out of bed. The DON said the Elopement Risk Assessment completed in May 2025 was incorrect because the nurse did it based on information prior to the resident going to the hospital. They said there were three residents in the elopement books on 8/30/25, but Resident #5 was not one of them. The DON said it wasn't until August that Resident #5 started walking good. She said the resident did not have an electronic monitoring device placed when she started walking again because she was not exit seeking. The NHA and DON reviewed Resident #5's care plan and confirmed she had been care planned for an electronic monitoring device from February through September 2025. They said during their investigation they could not determine how Resident #5 got downstairs or into the stairwell. They said they interviewed residents and staff and did not find anyone that saw Resident #5 on the elevator or that possibly rode the elevator down with her. The NHA said after getting downstairs Resident #5 somehow got into the stairwell which was only accessible from a locked door with a keypad code. They said from the stairwell there is an exit door to the outside and that is where the resident exited. The NHA said they knew she exited that door because the alarm was going off on that door, however she said the alarm was just a beeping sound that could only be heard in the stairwell or just outside of the stairwell doors . The NHA said the receptionist in the front did not hear the alarm from down the hall. The NHA and DON said the staff did not know Resident #5 had gotten downstairs and outside until Resident #13 brought her to the front of the building and the receptionist saw them. They said she had not gone missing and there was no elopement code called. They said they did do an elopement drill that evening after the incident. The NHA confirmed that Resident #5 was not observed exiting the facility and Resident #13 was the only person to see the resident outside. She said Resident #13 found Resident #5 and brought her back to the facility. A follow-up interview was conducted on 1/29/26 at 12:48 p.m. with the NHA. She stated that the electronic monitoring device is a nursing intervention and did not require a physician's order. She said they do typically put an order in the system to ensure the electronic monitoring device is checked daily by staff. An interview was conducted on 1/28/26 at 12:42 p.m. with Staff T, Occupational Therapist (OT). Staff F said Resident #5 was in the late stages of dementia and had trouble sequencing tasks. He said she would wander the halls and constantly went into other residents' rooms. Staff T said Resident #5 might go towards the elevators to get on, but she was easily redirected. He said she did follow other residents where they were going. Staff T said Resident #5 would have had the strength to open doors, but he didn't feel like she could have walked down four flights of stairs without falling. He said Resident #5 was alert and oriented to person only. Staff T said he didn't feel like staff are educated enough on treatment of dementia residents. An interview was conducted on 1/28/26 at 2:44 p.m. with Resident #5's Psychiatric-Mental Health Nurse Practitioner (PMHNP). She said Resident #5 was only oriented to person and was not able to care for herself. She said she didn't necessarily think of the resident as exit seeking because she was on the fourth floor, but the resident might follow other people out. An interview was conducted on 1/28/26 at 3:39 p.m. with Resident #5's primary care Advanced Registered Nurse Practitioner (ARNP). The ARNP said Resident #5 roamed the hallways and was only oriented to person. She said the resident couldn't answer questions appropriately, could walk independently, and would not be able to take care of herself. She said cognitively she didn't think Resident #5 would know what to do to care for herself. The ARNP said she could see Resident #5 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Aviata at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 2916 Habana Way Tampa, FL 33614	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	waiting and following someone on the elevator. She said Resident #5 was easily redirected. The ARNP said she was honestly not able to answer as to why Resident #5 didn't have an electronic monitoring device on. An interview was conducted on 1/28/26 at 2:58 p.m. with Resident #5's primary care provider (PCP). He said Resident #5 was ambulatory and definitely confused; I think from that point of view she was an elopement risk. The PCP said he did not feel that Resident #5 was capable of caring for herself outside the facility. An interview was conducted on 1/28/26 at 7:38 a.m. with the Resident Representative (RR) for Resident #5. The RR said Resident #5 did go out to the hospital and declined drastically in May but she bounced back quickly and was up and moving weeks later. The RR said she had been told by staff before that the resident tried to get out of the building, but she didn't know she ever did actually get out. The RR said she [Resident #5] was always trying to escape and was always wandering around. The RR said Resident #5 could get around good and would have been able to go down the stairs in August 2025. An interview was conducted on 1/28/26 at 12:01 p.m. with Resident Representative #2 for Resident #5. He said he was notified that the resident got out of the facility, but the facility really downplayed it. He said Resident #5 was free to do whatever she wanted here and staff didn't watch her. He said the resident had worked night shift throughout her life and would wander around all evening and night, going in and out or other resident rooms messing with their stuff and taking items. He said she was always wandering around, and he believed she was trying to get to the door/elevators to get out. He said staff told him multiple times that Resident #5 tried to get out. He said, I think she was doing it [trying to get to the doors and elevators] all the time. He said she was not watched or taken good care of. Review of a facility policy titled Missing Patient/Resident, revised 8/1/2020 showed:Overview:Staff will investigate cases of missing patient/resident and possible elopement. An elopement occurs when a patient/resident leaves the premises or a safe area without authorization and or any necessary supervision to do so, placing the patient at risk for harm or injury. Review of a facility policy titled Elopement/Wandering Risk Guideline, revised 8/1/2020, showed:Overview:To evaluate and identify patient/residents that are at risk for elopement and develop individualized interventions.Process:-Patient/Residents to be evaluated on admission, re-admission, 7 days post admission, quarterly, with a significant change in condition, and elopement event using the risk tool. -If a patient/resident is identified as being at risk complete an Elopement Risk Alert and obtain a photograph. -Initiate individualized interventions based on Patient/Residents' risk. -Document individualized interventions in the patient/resident Care Plan and Kardex [a quick reference document used by staff to provide care that contains essential resident information]. -If utilizing a wander monitoring system device check placement of the device every shift and functionality every day. -Maintain the Elopement Risk Alerts in an easily accessible location. -Complete routine elopement drills monthly and review in QAPI [Quality Assurance Performance Improvement] meeting. The facility's immediate actions to remove the Immediate Jeopardy included: Identified resident #5 was returned to facility on 8/30/2025 by Weekend Supervisor. On 8/30/2025 Resident #5 had a skin assessment, pain assessment, and change of condition completed with no negative findings. On 8/30/2025 Resident #5 Attending Physician was notified on 8/30/2025 and gave new orders for labs that resulted with ESBL [Extended-Spectrum Beta-Lactamase - a bacteria that produces enzymes resistant to most common antibiotics] in urine, new meds ordered 9/5/2025. Psych services was completed via telehealth visit was completed with resident no new orders received. On 8/30/2025 Resident #5 was placed on 1:1 and elopement assessment was completed placing a wanderguard to her lower extremity. Resident remained on 1:1 until 9/12/25 On 8/30/2025 Weekend Supervisor completed wanderguard function and placement for all current residents that are at risk for elopement with no negative findings. All (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Aviata at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 2916 Habana Way Tampa, FL 33614	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	residents' demographics were found in each resident elopement binder at nurse station, receptionist and therapy gym. On 8/30/2025 Resident #5 demographics and picture was added to the elopement binder by DON. On 8/30/2025 Door checks were completed by NHA to ensure all doors worked properly with no negative findings. On 8/30/2025 a 100% head count was completed by Weekend supervisor to ensure all residents were in facility with no negative findings. On 8/30/2025 100% of residents were re-assessed for elopement risk by DON and Designee. No new residents were identified. On 8/30/2025 an initial Elopement drill was complete on 8/30/2025 by NHA & Designee reviewed results and documented them on Elopement Drill QAPI [Quality Assurance Performance Improvement] Worksheet with no negative findings. On 8/30/2025 ED and DON gathered witness statements from residents and staff. On 8/31/2025 DON notified DCF [Department of Children and Families] & police of allegation of neglect and they did not accept the case. On 9/2/2025 Resident #5 was seen by psych services. She was alert with confusion, denied any distress, or intent to harm herself or others with no injuries with no complaints from the event. On 9/12/2025 Identified resident #5 discharged to a memory care unit as planned with IDT [Interdisciplinary Team], Family and Medical Director On 8/30/2025 Door guard was placed at door by NHA to ensure no one was able to leave from facility until screamers were installed. On 8/31/2025-9/7/2025 Elopement drills were completed every day, 3 times a day randomly. On 9/8/2025-9/30 Elopement drills were completed 1 time a week on random days. Monthly Drills have been completed monthly from October 2025- Current on random shifts and days. Results have been reviewed with QAPI Team. On 9/3/2025 Screamers were shipped from manufacturing company verified by Maintenance Director On 9/23/2025 a contractor came to facility to install cameras and new secure care boxes. Maintenance Director completed door checks to ensure they are functioning properly. On 9/23/2025 IDT & Clinical Consultant met to discuss removal of Door Guard. All agree On 9/23/2025 Security company came to facility to access possible amber alarm system and they were installed 10/7/2025 Security cameras were set up in the facility with main station located in NHA office. On 8/30/2025, 9/12/2025, 9/19/2025, and 9/26/2025 IDT including Medical Director met to review ADHOC [for this specific purpose] /QAPI plan with no negative findings. Medical Director reviewed and recommended no changes. On 8/30/2025 Education was initiated via phone [telephone] and in person with 100% of staff to include contract employees related to abuse & neglect, missing persons policy, elopement policy that included care plans and KARDEX for those at risk for wandering/elopement, and staff response to door alarms by NHA and Designee. Completed on 8/31/2025 On 8/30/2025 elopement drills were initiated for 100% of staff to include contracted employees by DON and Designee. Verification of the facility's removal plan was conducted by the survey team on 1/28 and 1/29/26. - Interviews were conducted with forty staff members, who worked across all shifts, including housekeeping, dietary, administrative/clerical, therapy, social services, CNA's, licensed nurses. The staff members were able to state that they had been trained and were knowledgeable about the new policies and procedures initiated by the facility. - A tour of the facility with the Director of Maintenance (DOM) and staff interviews confirmed alarms and cameras had been installed and were functioning - A review of in-service documentation revealed 100% of staff had acknowledged education and training related to abuse, neglect, and exploitation, resident supervision, elopement protocols, and following care plans. Based on verification of the facility's Immediate Jeopardy removal plan the immediate jeopardy was determined to be corrected on 9/3/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at the Bay	2916 Habana Way Tampa, FL 33614

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to serve Dinner meals in a timely manner and per the daily meal service timeframe for fourteen of seventeen meals reviewed (days 1/10/26, 1/11/26, 1/12/26, 1/13/26, 1/14/26, 1/15/26, 1/18/26, 1/19/26, 1/20/26, 1/21/26, 1/22/26, 1/23/26, 1/25/26, and 1/26/26). Findings included: On 1/26/2026 at 8:45 a.m. an interview was conducted with Resident #25. He stated he normally eats lunch in the dining room but eats his breakfast and dinner in his room by choice. The resident stated as of the past few months dinner comes up late per the meal service times. Resident #25 stated on his floor/unit he is supposed to get his meal served around 5:00 p.m. and most times he receives his meal anywhere from thirty minutes to two hours late. Resident #25 stated he has expressed this concern to the Director of Nursing and Nursing Home Administrator. The resident stated the issue has not been corrected. A medical record review revealed Resident #25 was admitted at the facility on 7/14/2022. Review of the most current Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed; (Cognition/Brief Interview Mental Status score 15 of 15, which indicated the resident was able to speak related to his medical care and services). On 1/26/2026 at 10:08 a.m. an interview was conducted with Resident #23. The resident stated he acts as the Resident Council President and he has been hearing complaints at resident meetings the past couple of months of meals not being brought to rooms in a timely manner. Resident #23 stated residents had complained meals are late all three meals to include Breakfast, Lunch, and Dinner and there are time meals do not get to the rooms for almost two hours late. Resident #23 confirmed he too receives meals late and will come late routinely around forty-five minutes to two hours late. Resident #23 stated he has spoken to the Dietary Manager about this issue and things have not been getting any better. A medical record review revealed Resident #23 was admitted at the facility on 3/25/2019. Review of the most current Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed; (Cognition/Brief Interview Mental Status score 15 of 15, which indicated the resident was able to speak related to his medical care and services). On 1/26/2026 at 1:40 p.m. an interview was conducted with Resident #12). She stated meals to include dinner is routinely served late routinely with meals served as late as two hours after the scheduled times. Resident #12 stated she is supposed to get dinner to her room around 5:00 p.m. and there are many time when times range from thirty minutes, forty-five minutes and many times up to two hours late. Resident #12 had notified the Dietary Manager of this concern a couple of months ago and things have not gotten any better. A medical record review revealed Resident #12 was admitted at the facility on 12/26/2025. Review of the most current Medicare 5 day Minimum Data Set (MDS) assessment dated [DATE] revealed; (Cognition/Brief Interview Mental Status score 15 of 15, which indicated the resident was able to speak related to his medical care and services). On 1/26/2026 at 2:20 p.m. an interview was conducted with Resident #24. He stated since he has been at this facility for about ten months, the meals come out late all the time. Resident #24 stated he has complained to aides, nurses, social worker, and Dietary Manager many times and the situation has not corrected. Resident #24 stated there are many times they do not get their dinner until 7:00 p.m. and sometimes after 8:00 p.m. Resident #24 stated he has overheard the kitchen cant keep staff and on his floor he should be receiving his dinner meal at around 5:00 p.m. Resident #24 stated he chooses to eat in his room for all three meals. A medical record review revealed Resident #24 was admitted at the facility on 3/26/2025. Review of the most current Annual Minimum Data Set (MDS) assessment dated [DATE] revealed; (Cognition/Brief (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at the Bay	2916 Habana Way Tampa, FL 33614

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview Mental Status score 13 of 15, which indicated the resident was able to speak related to his medical care and services). On 1/27/2026 at 8:11 a.m. The kitchen was entered and staff were still in process of plating breakfast trays. The kitchen was observed with one cook Staff O, and two aides Staff D and E. It had been addressed from the Nursing Home Administrator on 1/26/2026 the total resident census was 144. The cook Staff O was asked if the Dietary Manager was in and she could not say. Staff C stated he was not in yet but the Regional Dietary Manager was in the building. At 8:19 a.m. the Regional Dietary Manager Staff A walked into the kitchen after walking tray carts to floor/units. He stated he usually comes to assist the facility twice a week and the Dietary Manager was on his way in. The Regional Dietary Manager Staff A stated the kitchen staff are contracted and he has been coming to the facility frequently to assist as they have not been able to keep staff in the kitchen. The Regional Dietary Manager stated staff to include cooks and dietary aides are hired but they do not stay, so they routinely have shortages but he helps out with dietary needs to include cooking, prepping, plating trays, passing meal tray carts out to the floor and also with cleaning and paperwork. The Regional Dietary Manager stated he is a chef so he has been filling in at times to cook meals at the facility. The Regional Dietary Manager reveled Dietary staff start coming in the building to prep and cook breakfast at 6:00 a.m. and Dietary staff stay until around 9:30 p.m. Mondays - Sundays.At 10:32 a.m. met with the facility's Dietary Manager Staff B and he stated he works at the facility as the Dietary Manager six days a week and he tries to cover all three meal shifts. The Dietary Manager stated he has an Assistant Dietary Manager Staff P and that he covers the days he (Dietary Manager) is off. The Dietary Manager stated the kitchen staff are contracted services and he employs at the facility eleven (11) staff to include 3 Cooks for Breakfast, Lunch and Dinner but they are not at the facility at the same time, and 6 Dietary Aides to support breakfast, lunch and dinner meals. The Dietary Manager was not sure how many staff he should have total but did confirm he has been having staffing issues to include cooks mainly, but some Dietary Aides as well. The Dietary Manager stated he mainly has been having issues with getting meals out timely during mainly dinner service, and has been working with his Regional Dietary Manager to get fully staffed. When asked why he is having staffing issues, The Dietary Manger replied, I am not sure, but I hire cooks and they don't stay long. He continued to say; I have hired about 3 cooks the past two weeks and they never tell me why they leave. He stated he is having Dietary Aide staffing issues as well, but not as bad as the cooks staffing. The Dietary Manager Staff B stated his boss, the Regional Dietary Manager Staff A does come in at least twice a week to help with various things to include cooking, preparing food items, cleaning, serving/plating, and assists with paperwork, and has been doing so for over a month. The Dietary Manager confirmed they have been getting meals out late to residents during mainly the dinner meal service since around 11/2025 and they are trying to correct the issue. The Dietary Manager was unaware if residents were communicated with in relation to kitchen concerns and not being able to get meals out timely on a consistent basis. He confirmed the Nursing Home Administrator was aware but it was the contracted services department to staff the kitchen. Further interview with the Dietary Manager stated meals are sent out from the kitchen during the dinner meal service at: 1. Main dining room, residents do not use the dining room for this meal service; 2. Second floor - Hall Low at 5:30 p.m., Hall Hight at 5:45 p.m.; 3. Third floor - Hall Low at 6:30 p.m., Hall High at 6:45 p.m.; 4. Fourth floor - Hall Low at 6:00 p.m., and Hall High at 6:15 p.m. The Dietary Manager stated he generally will supervise the entire meal service to include the food preparation, food cooking, food plating, and meal trays sent out from the kitchen. He stated he does this most days and does come in for dinner meal services to supervise and help as well. The Dietary Manager did not have any (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at the Bay	2916 Habana Way Tampa, FL 33614

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation to support completed supervisory audits. He also stated for the entire month of 1/2026, about half or more of the dinner meals have been sent out and provided to residents late. He confirmed there were times where the dinner meal service was over an hour to an hour and a half late and he was trying to correct that. The Dietary Manager reveled that he has been in contact with his supervisor who was the Regional Dietary Manager and the Nursing Home Administrator and are trying to figure out ways to keep staffing and without so much turnover. At this point they (Regional Dietary Manager and Facility Dietary Manager) are continuing with hiring staff. The Dietary Manger stated he felt he should be and should have communicated with the Nursing Home Administrator more with the issues the kitchen is having with staffing. On 1/27/2026 at 12:00 p.m., review of the following documentation with the Dietary Manager revealed; Meal Cart Delivery Schedule document (not dated), currently used by Dietary Services. The document revealed meal times to include:Dinner meal service;Second Floor Low 4:45 p.m.; Second Floor High 4:30 p.m.; Fourth Floor Low 5:15 p.m., Fourth Floor High 5:00 p.m., Third Floor Low 5:45 p.m., Third Floor High 5:30 p.m. However, review of the daily Dining Services Cart Delivery Log, the meal cart delivery service times included for dinner; Second Low 5:30 p.m.; Second High 5:45 a.m.; Fourth Low 6:00 p.m., Fourth High 6:15 p.m.; Third Low 6:30 p.m., Third High 6:45 p.m.The Dietary Manager stated though they have the Meal Cart Deliver Schedule sheet posted in the kitchen, they generally use the times reflected in the Dining Services Care Delivery Log. The Dietary Manager provided the Dining Services Cart Delivery Log for review and stated meal delivery dates and times for the dinner meal services during the entire month of 1/2026; 1/10/2026 (Dinner Meal Service)a . Second Low hall Scheduled delivery at 5:30 p.m. Cart left kitchen at 6:32 p.m. (32 minutes after scheduled time).b . Second High hall Scheduled delivery at 5:45 p.m. Cart left kitchen at 6:41 p.m. (56 minutes after scheduled time).c . Fourth Low hall Scheduled delivery at 6:00 p.m. Cart left kitchen at 6:57 p.m. (57 minutes after scheduled time).d . Fourth High hall Scheduled delivery at 6:15 p.m. Cart left kitchen at 7:15 p.m. (60 minutes after scheduled time).e . Third Low hall Scheduled delivery at 6:30 p.m. Cart left kitchen at 7:30 p.m. (60 minutes after scheduled time).f . Third High hall Scheduled delivery at 6:45 p.m. Not documented when left kitchen 1/11/2026 (Dinner Meal Service)a . Second Low hall Scheduled delivery at 5:30 p.m. Cart left kitchen at 6:09 p.m. (39 minutes after scheduled time).b . Second High hall Scheduled delivery at 5:45 p.m. Cart left kitchen at 6:24 p.m. (39 minutes after scheduled time).c . Fourth Low hall Scheduled delivery at 6:00 p.m. Cart left kitchen at 6:42 p.m. (42 minutes after scheduled time). d . Fourth High hall Scheduled delivery at 6:15 p.m. Cart left kitchen at 6:45 p.m. (45 minutes after scheduled time).e . Third Low hall Scheduled delivery at 6:30 p.m. Cart left kitchen at 7:15 p.m. (45 minutes after scheduled time).f . Third High hall Scheduled delivery at 6:45 p.m. Cart left kitchen at 7:33 p.m. (48 minutes after scheduled time). 1/12/2026 (Dinner Meal Service)a . Second Low hall Scheduled delivery at 5:30 p.m. Cart left kitchen at 5:48 p.m. (18 minutes after scheduled time) b . Second High hall Scheduled delivery at 5:45 p.m. Cart left kitchen at 6:01 p.m. (16 minutes after scheduled time).c . Fourth Low hall Scheduled delivery at 6:00 p.m. Cart left kitchen at 6:26 p.m. (26 minutes after scheduled time).d . Fourth High hall Scheduled delivery at 6:15 p.m. Cart left kitchen at 6:41 p.m. (26 minutes after scheduled time).e . Third Low hall Scheduled delivery at 6:30 p.m. Cart left kitchen at 7:00 p.m. (30 minutes after scheduled time).f . Third High hall Scheduled delivery at 6:45 p.m. Cart left kitchen at 7:23 p.m. (38 minutes after scheduled time). 1/13/2026 (Dinner Meal Service)a . Second Low hall Scheduled delivery at 5:30 p.m. Cart left kitchen at 6:54 p.m. (24 minutes after scheduled time). b . Second High hall Scheduled delivery at 5:45 p.m. Cart left kitchen at 7:11 p.m. (1 hour and 26 minutes after scheduled time).c . Fourth Low hall Scheduled delivery at 6:00 p.m. Cart left (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Aviata at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 2916 Habana Way Tampa, FL 33614	

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kitchen at 7:32 p.m. (1 hour and 32 minutes after scheduled time).d . Fourth High hall Scheduled delivery at 6:15 p.m. Cart left kitchen at 7:45 p.m. (1 hour and 30 minutes after scheduled time).e . Third Low hall Scheduled delivery at 6:30 p.m. Cart left kitchen at 7:57 p.m. (27 minutes after scheduled time).f . Third High hall Scheduled delivery at 6:45 p.m. Cart left kitchen at 8:15 p.m. There was a note that read, Aide no show. (1 hour and 30 minutes after scheduled time). 1/14/2026 (Dinner Meal Service)a . Second Low hall Scheduled delivery at 5:30 p.m. Cart left kitchen at 6:39 p.m. (9 minutes after scheduled time).b . Second High hall Scheduled delivery at 5:45 p.m. Cart left kitchen at 6:53 p.m. (8 minutes after scheduled time).c . Fourth Low hall Scheduled delivery at 6:00 p.m. Cart left kitchen at 7:06 p.m. (1 hours and 6 minutes after scheduled time).d . Fourth High hall Scheduled delivery at 6:15 p.m. Cart left kitchen at 7:22 p.m. (1 hour and 7 minutes after scheduled time).e . Third Low hall Scheduled delivery at 6:30 p.m. Cart left kitchen at 7:37 p.m. (1 hour and 7 minutes after scheduled time). f . Third High hall Scheduled delivery at 6:45 p.m. Cart left kitchen at 8:01 p.m. There was a note that read, 0 Cook. (1 hours and 16 minutes after scheduled time). 1/15/2026 (Dinner Meal Service)a . Second Low hall Scheduled delivery at 5:30 p.m. Cart left kitchen at 5:53 p.m. (23 minutes after scheduled time). b . Second High hall Scheduled delivery at 5:45 p.m. Cart left kitchen at 6:05 p.m. (20 minutes after scheduled time).c . Fourth Low hall Scheduled delivery at 6:00 p.m. Cart left kitchen at 6:15 p.m. (15 minutes after scheduled time).d . Fourth High hall Scheduled delivery at 6:15 p.m. Cart left kitchen at 6:36 p.m. (21 minutes after scheduled time).e . Third Low hall Scheduled delivery at 6:30 p.m. Cart left kitchen at 6:50 p.m. (20 minutes after scheduled time).f . Third High hall Scheduled delivery at 6:45 p.m. Cart left kitchen at 7:14 p.m. (29 minutes after scheduled time). 1/18/2026 (Dinner Meal Service)a . Second Low hall Scheduled delivery at 5:30 p.m. Cart left kitchen at 5:57 p.m. (27 minutes after the scheduled time). b . Second High hall Scheduled delivery at 5:45 p.m. Cart left kitchen at 6:10 p.m. (25 minutes after scheduled time).c . Fourth Low hall Scheduled delivery at 6:00 p.m. Cart left kitchen at 6:30 p.m. (30 minutes after scheduled time).d . Fourth High hall Scheduled delivery at 6:15 p.m. Cart left kitchen at 6:41 p.m. (26 minutes after scheduled time).e . Third Low hall Scheduled delivery at 6:30 p.m. Cart left kitchen at 6:54 p.m. (24 minutes after scheduled time).f . Third High hall Scheduled delivery at 6:45 p.m. Cart left kitchen at 7:09 p.m. (24 minutes after scheduled time). 1/19/2026 (Dinner Meal Service)a . Second Low hall Scheduled delivery at 5:30 p.m. Cart left kitchen at 7:00 p.m. (30 minutes after scheduled time). b . Second High hall Scheduled delivery at 5:45 p.m. Cart left kitchen at 7:12 p.m. (1 hour and 27 minutes after scheduled time).c . Fourth Low hall Scheduled delivery at 6:00 p.m. Cart left kitchen at 7:33 p.m. (1 hour and 33 minutes after scheduled time.).d . Fourth High hall Scheduled delivery at 6:15 p.m. Cart left kitchen at 7:46 p.m. (1 hour and 31 minutes after scheduled time).e . Third Low hall Scheduled delivery at 6:30 p.m. Cart left kitchen at 7:57 p.m. (27 minutes after scheduled time).f . Third High hall Scheduled delivery at 6:45 p.m. Cart left kitchen at 8:13 p.m. (1 hour and 28 minutes after scheduled time). 1/20/2026 (Dinner Meal Service)a . Second Low hall Scheduled delivery at 5:30 p.m. Cart left kitchen at 5:40 p.m. (10 minutes after the scheduled time). b . Second High hall Scheduled delivery at 5:45 p.m. Cart left kitchen at 5:52 p.m. (7 minutes after the scheduled time).c . Fourth Low hall Scheduled delivery at 6:00 p.m. Cart left kitchen at 6:23 p.m. (23 minutes after the scheduled time).d . Fourth High hall Scheduled delivery at 6:15 p.m. Cart left kitchen at 6:36 p.m. (21 minutes after the scheduled time).e . Third Low hall Scheduled delivery at 6:30 p.m. Cart left kitchen at 7:02 p.m. (32 32 minutes after scheduled time).f . Third High hall Scheduled delivery at 6:45 p.m. Cart left kitchen at 7:13 p.m. (28 minutes after scheduled time. 1/21/2026 (Dinner Meal Service)a . Second Low hall Scheduled delivery at 5:30 p.m. Cart (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Aviata at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 2916 Habana Way Tampa, FL 33614	

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	left kitchen at 5:46 p.m. (16 minutes after the scheduled time). b . Second High hall Scheduled delivery at 5:45 p.m. Cart left kitchen at 6:01 p.m. (16 minutes after the scheduled time).c . Fourth Low hall Scheduled delivery at 6:00 p.m. Cart left kitchen at 6:17 p.m. (17 minutes after the scheduled time).d . Fourth High hall Scheduled delivery at 6:15 p.m. Cart left kitchen at 6:31 p.m. (16 minutes after the scheduled time).e . Third Low hall Scheduled delivery at 6:30 p.m. Cart left kitchen at 6:48 p.m. (18 minutes after the scheduled time).f . Third High hall Scheduled delivery at 6:45 p.m. Cart left kitchen at 7:01 p.m. (16 minutes after the scheduled time). 1/22/2026 (Dinner Meal Service)a . Second Low hall Scheduled delivery at 5:30 p.m. Cart left kitchen at 6:12 p.m. (42 minutes after the scheduled time). b . Second High hall Scheduled delivery at 5:45 p.m. Cart left kitchen at 6:24 p.m. (39 minutes after the scheduled time).c . Fourth Low hall Scheduled delivery at 6:00 p.m. Cart left kitchen at 6:43 p.m. (43 minutes after the scheduled time). d . Fourth High hall Scheduled delivery at 6:15 p.m. Cart left kitchen at 7:01 p.m. (16 minutes after the scheduled time).e . Third Low hall Scheduled delivery at 6:30 p.m. Cart left kitchen at 7:15 p.m. (30 minutes after the scheduled time).f . Third High hall Scheduled delivery at 6:45 p.m. Cart left kitchen at 7:39 p.m. (54 minutes after scheduled time). 1/23/2026 (Dinner Meal Service)a . Second Low hall Scheduled delivery at 5:30 p.m. Cart left kitchen at 6:45 p.m. (1 hour and 15 minutes after scheduled time).b . Second High hall Scheduled delivery at 5:45 p.m. Cart left kitchen at 7:00 p.m. (1 hour and 15 minutes after scheduled time).c . Fourth Low hall Scheduled delivery at 6:00 p.m. Cart left kitchen at 7:17 p.m. (1 hour and 17 minutes after scheduled time).d . Fourth High hall Scheduled delivery at 6:15 p.m. Cart left kitchen at 7:40 p.m. (1 hour and 25 minutes after scheduled time).e . Third Low hall Scheduled delivery at 6:30 p.m. Cart left kitchen at 8:02 p.m. (1 hour and 32 minutes after scheduled time).f . Third High hall Scheduled delivery at 6:45 p.m. Cart left kitchen at 8:25 p.m. (1 hour and 40 minutes after scheduled time). 1/25/2026 (Dinner Meal Service)a . Second Low hall Scheduled delivery at 5:30 p.m. Cart left kitchen at 6:34 p.m. (1 hour and 4 minutes after scheduled time).b . Second High hall Scheduled delivery at 5:45 p.m. Cart left kitchen at 6:46 p.m. (1 hour and 1 minute after scheduled time).c . Fourth Low hall Scheduled delivery at 6:00 p.m. Cart left kitchen at 7:06 p.m. (1 hours and 6 minutes after scheduled time).d . Fourth High hall Scheduled delivery at 6:15 p.m. Cart left kitchen at 7:20 p.m.e . Third Low hall Scheduled delivery at 6:30 p.m. Cart left kitchen at 7:33 p.m. (1 hour and 3 minutes after scheduled time).f . Third High hall Scheduled delivery at 6:45 p.m. Cart left kitchen at 7:54 p.m. (1 hour and 9 minutes after scheduled time). 1/26/2026 (Dinner Meal Service)a . Second Low hall Scheduled delivery at 5:30 p.m. Cart left kitchen at 6:02 p.m. (32 minutes after scheduled time).b . Second High hall Scheduled delivery at 5:45 p.m. Cart left kitchen at 6:12 p.m. (27 minutes after scheduled time).c . Fourth Low hall Scheduled delivery at 6:00 p.m. Cart left kitchen at 7:00 p.m. (1 hour after scheduled time).d . Fourth High hall Scheduled delivery at 6:15 p.m. Cart left kitchen at 6:20 p.m. (5 minutes after scheduled time).e . Third Low hall Scheduled delivery at 6:30 p.m. Cart left kitchen at 6:38 p.m. (8 minutes after scheduled time).f . Third High hall Scheduled delivery at 6:45 p.m. Cart left kitchen at 7:03 p.m. (18 minutes after scheduled time). On 1/27/2026 at 2:00 p.m. an interview with the Nursing Home Administrator confirmed the kitchen has been having problems maintaining staff to include cooks and dietary aides. She revealed the kitchen staff is through a contracted service and she does communicate between the Dietary Manager, and the Regional Dietary Manager. The Nursing Home Administrator stated they continue to advertise and hire new staff, but they do not stay long. On 1/28/2026 at 8:15 a.m. an interview with the Nursing Home Administrator stated the facility did not have a specific Policy and Procedure related to honoring meal service times. The Nursing Home Administrator confirmed residents have the right (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Aviata at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 2916 Habana Way Tampa, FL 33614	

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to receive their meals timely, and per the meal service schedule.