STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105443	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Venice	1026 Albee Farm Rd Venice, FL 34285

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 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 observation, record review, review of facility's policy and procedure, staff and resident interviews, the facility failed to provide assistance with showers, personal hygiene and incontinent care as outlined in the resident's care plan and according to residents' preferences for 3 (Residents #6, #13 and #57) of 5 dependent residents reviewed for activities of daily living (ADL's).The findings included:Review of the facility's policy titled, Activities of Daily Living, Supporting (no effective date) revealed, Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. The policy stated, Appropriate care and services are provided for residents who are unable to carry out ADLs (activities of daily living) independently. The policy defined hygiene as bathing, dressing, grooming, and oral care. The policy defined elimination as toileting. The policy further stated, refusal and details of the interventions refused are documented in the resident's clinical record. Review of a facility provided incident investigation for Resident #6 showed an allegation of neglect on 9/7/25 for right ear is full of wax, hair greasy, horrible dandruff. On 2/2/26 at 7:56 a.m., Resident #6 was observed in bed. The resident was noted to have a strong foul odor. Resident #6 only responded yes to interview questions. When responding, a white gunk substance was observed in Resident #6's mouth. A foul odor was noted from the resident's mouth. Resident #6 was determined to be non-interviewable. Record review for Resident #6 revealed a date of admission of 9/19/19. Diagnoses included anoxic brain injury (brain is completely deprived of oxygen, causing brain cells to die), contracture of the right elbow, left hand/elbow, and need for assistance with personal care. The clinical record noted on 1/2/26, Resident #6 scored 3 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Review of the care plan initiated on 10/7/19 and revised on 9/24/25 revealed Resident #6 had an ADL self-care performance deficit related to seizure disorder, chronic hypoxic ischemic brain injury, status post cardiac arrest, and impaired communication and cognition. The care plan noted Resident #6 was totally dependent on 1 staff for personal hygiene and oral care. The interventions included for the CNA to provide oral hygiene every shift and as needed; oral care routine in the morning after meals and at bedtime: Brush teeth, clean gums with toothette (foam-tipped applicator), rinse mouth with wash. On 2/2/26 at 2:58 p.m., an unidentified Certified Nursing Assistant (CNA) was observed exiting Resident #6's room and said she had just finished providing care to the resident. During observation and interview, Resident #6's lips were observed to be dry. Hair growth was observed on the resident's upper lip. A white, gunky substance was observed in the resident's mouth. Resident #6's arms and hands were observed contracted. A chunk of black hair was observed in Resident #6's contracted right hand. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/3/26 at 9:15 a.m., Resident #6 was observed with dry lips and white debris in her mouth. A foul odor was noted from the resident's mouth. Review of Resident #6's CNA documentation revealed CNAs worked three 8-hour shifts per day. The CNA documentation for November 2025 lacked documentation oral care was provided for 9 shifts. N/A (not applicable) was documented for oral care for 30 shifts. The CNA documentation for December 2025 lacked documentation oral care was provided for 7 shifts. N/A was entered for oral care for 35 shifts. 3 shifts were documented as Resident #6 being independent to perform oral hygiene. 2 shifts documented Resident #6 as being a setup assistance for oral care. The CNA documentation for January 2026 lacked documentation oral care was provided for 5 shifts. N/A was entered for oral care for 29 shifts. 4 shifts were documented as Resident #6 being independent to perform oral hygiene. 1 shift documented Resident #6 as being a setup assistance for oral care. Review of the dental hygienist note dated 12/8/25 revealed, Patient's teeth were not scaled (deep cleaning that removes hardened plaque and bacteria from teeth surface) due to the presence of heavy gross calculus and patient's inability to open their mouth adequately. The note stated that scaling could not be done without suction since a dislodged calculus could present an aspiration (entering of foreign materials into the airway/lungs) hazard. On 2/5/26 at 8:18 a.m., in an interview CNA Staff A said oral care is done every shift. She said they obtain their information on how often tasks should be completed by reviewing the Kardex (Provides instructions for care) and the care plan. The CNA said that everything was documented in the electronic chart. When asked to see the supplies used to provide oral care to Resident #6 (toothbrush, toothette, wash), CNA Staff A searched Resident #6's rooms and drawers. She said she was not able to locate oral care supplies in the resident's room. Further review of Resident #6's care plan revealed the resident had functional bladder incontinence secondary to self-care deficit (Revision date of 1/10/2024) and bowel incontinence related to immobility, and hypoxic brain injury (Revision date of 12/12/2019). The interventions included for the resident to remain free from skin breakdown due to incontinence and brief use. The interventions included to check resident frequently and assist with toileting/incontinent care as needed, change disposable briefs frequently and as needed, clean peri-area with each incontinence episode, Review of the CNA documentation for July 2025 failed to reveal documentation of bladder incontinence care for 34 shifts. Review of the CNA documentation for August 2025 failed to reveal documentation of bladder incontinence care for 21 shifts. 2 shifts were documented as n/a. Review of the CNA documentation for September 2025 failed to reveal documentation of bladder incontinence care for 6 shifts. On 2/5/26 at 8:18 a.m., in an interview CNA Staff A said incontinent residents are checked every 2 hours. CNA Staff A said Resident #6 was completely dependent on staff for oral and incontinence care (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and the care provided is documented in the electronic chart. On 2/5/26 at 8:29 a.m., in an interview related to oral care and incontinent care, CNA Staff B said they do oral care every morning for residents and residents are checked for incontinence every 2 hours. Staff B said the resident's Kardex or the care plan provides information on how often tasks should be completed, oral care and incontinent care are documented in the electronic charting system. After reviewing the lack of documentation of oral care and/or incontinent care for multiple shifts from July 2025 through January 2026, CNA Staff B said, If it's not documented, it didn't happen. On 2/5/26 at 8:34 a.m., in an interview Licensed Practical Nurse (LPN) Staff C said she was assigned to Resident #6 for the shift. LPN Staff C said incontinence care is done every 2 hours and oral care is done twice a day and as needed. LPN Staff C said you can find out how often tasks should be completed by reviewing the residents' medication record, treatment record or Care Plan. LPN Staff C said the CNAs document incontinence and oral care in the electronic record. LPN Staff C reviewed the CNA documentation for oral care and incontinence care for Resident #6 and verified there was no documentation of oral care and/or incontinence care for multiple shifts from July 2025 through January 2026. LPN Staff C said, it looks like it has not been done. On 2/5/26 at 8:39 a.m., in an interview LPN Staff D said incontinence care is done every 2 hours and oral care is done every morning and night. Upon reviewing the lack of CNA documentation that oral care and/or incontinent care were provided for multiple shifts from July 2025 through January 2026 for Resident #6, LPN Staff D said, blank spaces mean it was not done. On 2/5/26 at 8:42 a.m., in an interview CNA Staff E said incontinent care should be done every 2 hours and oral care should be done before and after meals. CNA Staff E said tasks that need to be completed show up in the resident's electronic medical record. CNA Staff E said once interventions are added to the resident's care plan, it reflects on the task list. Upon reviewing Resident #6's incontinence and oral care documentation, CNA Staff E said, if there is no documentation, it was not done. On 2/5/26 at 9:55 a.m., in an interview the Director of Nursing (DON) said incontinence care should be done every 2 hours, and oral care should be done every shift and as needed. The DON said incontinence and oral care show up on the resident's electronic medical record every shift as a task for staff to complete. The DON said Resident #6 should be receiving incontinence care every 2 hours and oral care every shift. Upon reviewing the CNA documentation for oral care and incontinence care, the DON confirmed the lack of documentation of oral care and/or incontinent care for multiple shifts from July 2025 through January 2026. When asked if Resident #6 was independent or set-up assistance for oral care, the DON said no. On 2/5/26 at 10:26 a.m., in an interview the Nursing Home Administrator (NHA) said her expectation is to document the care provided. Review of the clinical record revealed Resident #13 had a date of admission of 10/23/25. Diagnoses included muscle weakness, repeated falls, adult failure to thrive, and anxiety. Review of the Quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 1/10/26 documented Resident 13 was always incontinent of bowel and bladder and required supervision/touching assistance with bathing, dressing, and toileting. The MDS noted Resident #13 scored 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognitive skills for (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	daily decision making were intact. Review of the care plan initiated on 11/3/25 revealed that Resident #13 had an ADL self-care performance deficit related to activity intolerance, fatigue, impaired balance, and generalized weakness. The interventions included for staff to check for incontinence upon rising, before and after meals and as required. Staff was to wash, rinse and dry perineum. Change clothing as needed after incontinence episodes. Resident #13 required supervision on 1 staff to provide shower. On 2/2/2026 at 12:21 p.m., in an interview Resident #13 said she does not get changed when she is wet. Resident #13 said, I wait for hours when I'm wet and it hurts. The resident said she gets an irritation in her upper inner thighs from the brief being wet and rubbing. When she requests assistance, the staff come in and ask what she needs. They say, Ok, someone will be here to change you and guess what? No one comes back for 30 minutes to an hour. Resident #13 said, They don't give me showers, I don't know why. On 2/3/2026 at 1:00 p.m., in an interview Resident #13 said, Some mornings I'm wet and they come in with my breakfast tray and put it on the table. I don't want to eat when I'm wet. Resident #13 said she was scheduled for showers on Wednesday and Saturday on the day shift but, They just don't want to do it and I can't walk. She said she sometimes refuses her shower but not often. She said she was tired and had no strength to get out of bed. Review of the CNA documentation for December 2025 and January 2026 revealed: Resident #13's shower days were scheduled for Wednesday and Saturday on the 7:00 a.m. to 3:00 p.m., shift. On 12/1/25, 12/3/25, and 1/10/26, a bed bath was provided in place of the scheduled shower. On 12/6/25, 12/17/25, 12/24/25, 1/7/26, and 1/14/26, NA was documented. On 12/13/25 and 1/3/26, no care was documented. On 1/24/26, 1/28/26 and 1/31/26, Resident #13 refused the shower. Review of the documentation for bladder function revealed: For the 7:00 a.m., to 3:00 p.m., shift, no care was documented on 12/6/25, 12/13/25, 12/23/25, 12/26/25, 12/31/25, 1/3/26, 1/18/26, and 1/19/26. On 12/2/25, 12/4/25, 12/8/25, 12/21/25, 12/22/25 NA was documented. For the 3:00 p.m., to 11:00 p.m., shift, no care was documented on 12/22/25, 12/24/25, and 12/27/25. On 12/21/25, 12/30/25, 1/1/26, 1/5/26, 1/6/26, 1/15/26, 1/16/25, 1/19/26, 1/21/26, 1/23/26, 1/24/26, 1/25/26, 1/27/26 and 1/28/26, NA was documented. For the 11:00 p.m., to 7:00 a.m., shift, no incontinent care was documented on 12/19/25, 12/27/25, 12/29/25 and 12/31/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/1/25 through 12/18/25, 1/2/26, 1/4/26, 1/27/26, 1/9/26, and 1/19/26 NA was documented. Review of Resident #57's clinical record revealed an admission date of 6/28/23 and a readmission date of 7/12/23. Diagnoses included cerebral palsy, epilepsy, major depressive disorder, stage 2 chronic kidney disease, chronic a-fib and need for assistance with personal care. Review of the Quarterly MDS with an ARD of 8/22/25 revealed Resident #57 scored 10 on the BIMS, indicating moderately impaired cognition. The MDS noted that the resident was frequently incontinent of bowel and bladder and required partial to moderate assistance with bathing, dressing, toileting and personal hygiene. Review of the Care Plan initiated 7/20/23 revealed Resident #57 had an ADL self-care performance deficit related to fatigue, impaired balance, limited mobility, and cerebral palsy. The interventions included: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse: Provide sponge bath when a full bath or shower cannot be tolerated. The resident requires partial assistance by 1 staff for toileting and with bathing/showering 2 times weekly and as necessary. Staff was to encourage the resident to use bell to call for assistance. On 2/2/26 at 3:34 p.m., during observation and interview, Resident #57 was noted to have a foul urine smell, and foul breath from 3 feet away. The Resident's nails extended 1/2 inch from the fingertips. An accumulation of black substance was observed under the nails. In an interview, Resident #57 said staff took his nail clippers. He said he's been asking for someone to trim his nails, but they have not done it. Resident #57 said no one comes to set him up to brush his teeth. Resident #57 had an unopened tube of toothpaste from his drawer. He said, Today they put this tube of toothpaste in my drawer. Where was it before? I ask for help and they don't do it, I'm here because I need help. What am I supposed to do? Resident #57 said he has been asking to go to bed since lunch was over. They told him to go to his room and put the light on. Resident #57 said, What good does it do if no one comes. Resident #57 said staff don't come to help him use the toilet. He said he wheels himself in the bathroom, grabs the bar and try to pull his pants down, but he can't do it. Resident #57 said, I end up wetting myself and it is horrible. On 2/3/26 at 9:36 a.m., Resident #57 was observed in his room in bed. The resident remained with his fingernails extending 1/2 inch from the fingertip with a black substance under the nails. He said his nails were not trimmed or cleaned and he did not receive assistance with oral care. The tube of toothpaste observed on 2/2/26 remained unopened. Resident #57 said he was not changed during the night and did not like being wet. Review of the CNA documentation for December 2025, and January 2026 revealed: Resident #57's shower days were Monday and Thursday during the 7:00 a.m., to 3:00 p.m., shift. On 12/1/25, and 1/22/26, a partial bed bath was documented. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/25, 12/22/25, 12/25/25, 12/29/25, 1/12/26, 1/19/26, 1/26/26 and 1/29/26 NA was documented. On 12/28/25, 1/5/26 and 1/8/26 there was no shower documented. Review of the CNA documentation of incontinent care/toileting care revealed: For the 7:00 a.m., to 3:00 p.m., shift, there was no documentation of incontinent/toileting care on 12/6/25, 12/13/25, 12/18/25, 1/3/26, 1/5/26, 1/6/26, and 1/17/26. On 12/2/25, 12/4/25, 12/8/25, 12/20/25,1/15/26, 1/28/26, 1/29/26, and 1/31/26, NA was documented. For the 3:00 p.m., to 11:00 p.m., shift, there was no documentation of incontinent/toileting care on 12/12/25, 12/20/25, and 1/3/26. On 1/6/26, 1/27/26, NA was documented. For the 11:00 p.m., to 7:00 a.m., shift, there was no documentation of incontinent/toileting care on 12/31/25,1/21/26, 1/22/26, 1/25/26, 1/26/26, 1/27/26 and 1/31/26. On 1/2/26, 1/8/26, 1/9/26, 1/16/26, 1/19/26, 1/23/26, 1/28/26, 1/29/26 and 1/30/26, NA was documented. On 2/3/26 at 4:00 p.m., Resident #57 was observed in the hallway in his wheelchair outside of the dining room. The resident was noted to have a strong, unpleasant body odor. The resident's fingernails remained with a black substance. Resident #57 was wearing a blue shirt covered in white flakes of dried skin. In an interview, Resident #57 said no one assisted him with care this morning. He said, They think I can do it myself, but I need help. On 2/3/26 at 4:10 p.m., in an interview CNA Staff Q said they follow the shower list at the desk. CNA Staff Q demonstrated how they pull up the resident care Kardex on the computer system to find the shower preferences of the resident. She said if someone wanted a shower and it was not their day, of course if I have the time, I will do it. Whatever the resident wants. Nail care is done when the resident asks for it. On 2/4/26 at 11:40 a.m., in an interview CNA Staff A said if a resident refuses a shower they go back and ask a couple of times and maybe offer a bed bath. If the resident continues to refuse, they tell the nurse. The nurse will try and encourage them. If the resident still doesn't want a shower or a bed bath the resident and the CNA sign a form that is found in the shower book. The form is then given to the nurse. CNA Staff A said they check on incontinent residents every 2 hours. She said they take residents to the bathroom upon request.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident and staff interviews, the facility failed to provide resident centered activities to meet the interests of 2 (Residents #43 and #6) of 3 residents reviewed for activities.The findings included:Review of the facility's policy titled, Group Programs and Activities Calendar revised June 2018 revealed, Residents are encouraged to participate in all group activities, especially those that are best suited for their interests and physical, mental, and emotional needs . Activities professionals plan scheduled activities for the month . Review of Resident #43's clinical record revealed an admission date of 11/20/24. Diagnoses included Alzheimer's Disease, Major Depressive Disorders and Adjustment Disorder. Resident #43 resided on the secured memory care unit of the facility. Review of the Annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 11/27/25 revealed Resident #43 scored 08 on the Brief Interview for Mental Status, indicating severe cognitive impairment. The MDS noted that it was somewhat important to the resident to go outside to get fresh air when the weather is good. Review of the care plan revealed Resident #43 was dependent on staff for meeting emotional, intellectual, physical and social needs related to physical limitations. The care plan goals noted Resident #43, loves snacks and going outside in the sun and The resident will attend/participate in Community Life activities of choice 3-5 times by next review date. The interventions included to provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility. Review of the Community Life Progress Review dated 11/6/25 revealed Resident #43's physical reaction during programming and emotion usually expressed was, Happy she enjoys being outside in the sun. On 2/2/26 at 11:25 a.m., in an interview Resident #43 said she was legally blind and struggles with activities. Resident #43 said she wants to go outside for 15 minutes a day, but no one ever lets her. Resident #43 said she has not been outside for years. Review of Resident #43's facility provided, Individual Resident Daily Activities log for November 2025, December 2025 and January 2026 revealed the resident went to the patio once on 11/23/25 and once on 12/23/25. No other outside activities were documented. Review of Resident #43's electronic medical record responses for Group Activities from 1/6/26 to 2/3/26 showed no participation of outside activities. Review of Resident #43's electronic medical record responses for one on one activities from 1/6/26 to 2/3/26 had no responses. Review of Resident #43's electronic medical record responses for selected directed activities from 1/6/26 to 2/3/26 showed no completion of outside activities. Review of the activities calendar for February 2026 showed no scheduled outside activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/26 at 9:06 a.m., in an interview Certified Nursing Assistant (CNA) Staff F said when deciding activities, the residents will either tell us what they want to do, or we follow the activities calendar. CNA Staff F said the memory care residents never go outside in the sun. On 2/4/26 at 9:11 a.m., in an interview CNA Staff E said she has worked here a long time and knows the residents' activities preferences. CNA Staff E said the residents on the memory care unit do not go outside. CNA Staff E said they used to go outside a long time ago, but the previous ownership stopped that. CNA Staff E said the previous ownership would not even let the memory care resident's go outside with family. CNA Staff E said Resident #43 used to like to go outside. When asked if the patio is ever used, CNA Staff E said no one uses the patio. On 2/4/26 at 9:17 a.m., in an interview Registered Nurse (RN) Staff G said they have an activities person who organizes the activities for the memory care residents. RN Staff G said the residents do not go outside in the sun. RN Staff G said she has worked on the memory care unit for a long time and has never seen the patio used. On 2/4/26 at 9:24 a.m., in an interview the Activities Director said the resident's Care Plan reflects their activities preference. The Activities Director confirmed that Resident #43's Care Plan says she likes to go outside in the sun. The Activities Director said activities preferences are determined through the community life assessment. The Activities Director said the community life assessment is completed upon admission, quarterly and when there is a change in condition. The Activities Director said her expectation is if a resident expresses an activities preference, it goes on the Care Plan and needs to be done. The Activities Director confirmed Resident #43 does not go outside. Review of the clinical record revealed Resident #6 had an admission date of 9/19/2019. Diagnoses included anoxic brain injury, cardiac arrest, seizures, contractures of left and right hands and elbows, anxiety and major depressive disorder. Review of the plan of care for Resident #6 initiated on 10/8/2019 specified the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to brain trauma, cognitive deficits, immobility, and is alert with severely impaired cognition. The care plan documented the resident spends most time in her room in bed watching television (TV), she enjoys a variety on TV and listening to music on her radio and enjoys a [NAME] of music stations. The goal for Resident #6 documented to be offered music daily. On 2/2/26 at 10:17 a.m., and 4:00 p.m., Resident #6's bedroom door was observed to be closed. Observation of the room revealed Resident #6 was in bed awake. No television or radio were turned on. Review of the activity calendar for 2/2/26 revealed activities for day were 8:30 a.m., Coffee Social, 10:00 a.m., Church Volunteer Group, 1:30 p.m., Valentine Trivia, 2:23 p.m., Choice Stations/1-1, 4:30 p.m., Netflix and chill, 5:30 p.m., Courtyard Connection. On 2/3/2026 at 9:40 a.m., and 2:11 p.m., Resident #6 was observed in her room in bed with the TV and radio off. The bedroom door was closed and the lights were off. The room was dark and the privacy curtain was pulled blocking light from the window. Resident #6 was awake and was able to answer yes and no questions. When asked if she enjoyed listening to music or watching television, Resident #6 replied, Yes. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the activity calendar for 2/3/26 revealed the activities for the day were 8:30 a.m., Coffee Social, 10:00 a.m., Seated Upper Extremity Exercises, 1:30 p.m., Heartfelt Creations, 2:30 p.m., Choice Station/1-1, 4:30 p.m., Netflix and Chill, 5:30 p.m., Golden Hour Club. Review of the Activity Documentation for Resident #6 for December 2025 revealed one-to-one activities were provided 7 of 31 days. Group activities were provided 3 of 31 days. Review of the Activity Documentation for January 2026 revealed one-to-one activities were provided 3 of 31 days. Group activities were provided to Resident #6 on 4 of 31 days. On 2/3/2026 at 5:10 p.m., in an interview the Activity Director said Resident #6 was her project. She said, I'm trying to get her to group activities. Last month she came out for 2. When asked about activities provided for the resident when she was in her room, the Activity Director said, There is a radio and a TV that are on for her. She loves music. The multiple observations of Resident #46 lying in bed in her room with the television and radio off were shared with the Activity Director. She said, Well, the CNAs are supposed to put it on for her.

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	105443	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Venice	1026 Albee Farm Rd Venice, FL 34285

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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 policy and facility staff interview, the facility failed to report an allegation of neglect to the proper authorities within the required timeframe for 1 (Resident #80) of 3 residents reviewed with an allegation of neglect.The findings included.Review of the facility's policy titled Risk Management: Incident Management noted the facility's Administrator was responsible for oversight of all Risk Management activity and assuring resident safety, including the freedom from risk of abuse as holding the highest priority. Abuse will not be tolerated by anyone including staff, residents/patient, volunteers, family members or legal guardians or any other individual. Allegations of abuse, neglect, exploitation/misappropriation, injuries of unknown origin and potentially Resident to Resident Altercation will be reported per federal regulation.The policy also noted, 3. Documenting . e. Nursing Home Administrator is responsible for doing the Federal Immediate and Five-Day Reports, Adverse Incident Report and DCF [Department of Children Family] notification. Review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation and Misappropriation with an effective date of 11/30/14 and a revision date of 11/16/22, revealed, 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. 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.5. Investigation. The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation.Preliminary investigation: Immediately upon an allegation of abuse or neglect, the suspects(s) shall be segregated from residents pending the investigation of the resident allegation.Review of Report: Report the results of all investigation to the Executive Director or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.Review of the facility provided log for Nursing Home Federal Reports revealed the facility filed a Federal Immediate/Day 1 report on 6/28/25 for an allegation of neglect on 6/8/25 for Resident #80. The allegation of neglect investigation said Resident #80 was served the wrong textured diet on 6/8/25 causing a piece of Italian sausage to get caught in her throat. A nurse in the dining room assessed the resident with no air exchanged and initiated the Heimlich maneuver with one abdominal thrust resulting in a piece of sausage being dislodged. Resident #80's medical record revealed she was on a dysphagia puree diet with honey thickened fluids at the time of the event. A chest x-ray was ordered and results stated Resident #80's lung fields were clear without evidence of infiltration, effusion, or pneumothorax. Resident #80 was seen by the Respiratory Therapist, Pulmonologist and the primary care physician with no significant findings.The facility filed the Five-Day report on 7/7/25 stating after a complete and thorough investigation including Resident #80's medical record review and interviews with staff the allegation of neglect was verified. Resident #80 did receive the wrong meal tray which resulted in a choking episode with the Heimlich being performed. As part of the facility's corrective actions taken, they provided education to the Executive Director (ED) and Director of Nursing (DON) regarding timely reporting. On 2/4/26 at 9:48 a.m., in an interview with the DON and ED, they confirmed the facility filed a Federal Immediate report for neglect on 6/28/25 related to Resident #80 being served the wrong textured diet on 6/8/25, causing Resident #80 to choke, and the nurse in the dining room performing the Heimlich maneuver resulting in a piece of sausage being dislodged. The DON and ED said the facility's Federal Immediate report stated the ED was notified on 6/8/25 at 1:01 p.m. of Resident #80 being served the incorrect texture diet but the ED did not file the Federal Immediate report until 6/28/25, 20 days after the incident. They confirmed the facility's Five-Day report dated 7/7/25, concluded the allegation of neglect was verified because Resident #80 did receive the wrong (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meal tray which resulted in a choking episode with the Heimlich being performed. They also confirmed the facility's Five-Day report concluded that the Federal Immediate report was filed 20 days late and part of the facility's corrective action taken included education with the ED and DON regarding timely reporting of the Federal Immediate report as required per their Risk Management: Incident Management and the Abuse, Neglect, Exploitation and Misappropriation policies and procedures.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, record review, and staff interviews, the facility failed to provide appropriate care in accordance with current standards of care to prevent complications of tube feeding for 1 (Resident #81) of 3 residents reviewed with feeding tubes (tube inserted directly in the stomach to deliver liquid nutrition, fluids, and medications).The findings included:Review of the clinical record for Resident #81 revealed an admission date of 1/30/26. Diagnoses included unspecified brain injury, fracture of the neck and dysphagia (difficulty swallowing).Review of the admission Minimum Data Set (MDS) Assessment with an assessment reference date of 2/2/26 revealed Resident #81scored 08 on the Brief Interview for Mental Status, indicating moderate cognitive impairment. The MDS noted Resident #81 had a feeding tube had a feeding tube and was dependent on staff for nutrition.Review of the physician's order dated 1/30/26 revealed to elevate the head of the bed 30-45 degrees during enteral feeding or flushing every shift.Review of the Care Plan initiated on 2/2/26 revealed Resident #81 requires tube feeding related to abnormal swallow evaluation status post bike accident.The interventions as of 2/2/26 included that the resident needs the head of the bed elevated 45 degrees during and thirty minutes after tube feed; monitor/document/report any signs of symptoms of aspiration; the resident is dependent with tube feeding and water flushes.On 2/2/26 at 11:06 a.m., and 2/3/26 at 1:11p.m., Resident #81 was observed lying completely flat in bed on his back with the head of the bed down and leveled with the foot of the bed. The pump delivering the tube feeding was on and indicated the feeding was infusing at 70cc/hour.On 2/3/26 at 1:22 p.m., Licensed Practical Nurse (LPN) Staff K observed Resident #81and verified he was lying completely flat in bed while the feeding was infusing. She said lying flat in bed while the feeding was infusing created a risk for aspiration. LPN Staff K said the head of the bed should be raised 45 degrees when the feeding is infusing.On 2/3/26 at 3:07 p.m., and 2/4/26 at 10:16 a.m., Resident #81 was observed lying completely flat in bed on his back. The pump delivering the tube feeding was on and indicated the feeding was infusing at 70cc/hour. On 2/4/26 at 10:20 a.m., LPN Staff H observed Resident #81and verified he was lying completely flat in bed while the feeding was infusing. In an interview LPN Staff H said the head of the bed should be elevated at a 45-degrees angle while the feeding is infusing. She said if the head of the bed is not elevated when the tube feeding is running, the resident is at risk for nausea, vomiting and aspiration.On 2/5/26 at 10:30 a.m., in an interview the Director of Nursing (DON) said the head of the bed should be raised 45 degrees when the tube feeding is running to prevent aspiration.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and staff interview, the facility failed to ensure the irregularities identified during the pharmacy consultant's drug regimen review were acted upon for 1 (Resident #13) of 5 residents reviewed for unnecessary medications.The findings included:Review of the facility policy Pharmacy Services - Role of the Consultant Pharmacist, documented The Consultant Pharmacist will provide specific activities related to medication regime review including:a. A documented review of the medication regime of each resident at least monthly.b. Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications including medication irregularities.Review of the clinical record for Resident #13 revealed an admission date of 10/23/25. Diagnoses included repeated falls, muscle weakness, depression and anxiety.Review of the Consultant Pharmacist Medication Review dated 10/31/25, the Pharmacist documented The use of Atorvastatin and Fenofibrate (medication used to lower cholesterol and triglycerides) should be avoided due to an increase of myopathy (muscle weakness and fatigue) and rhabdomyolysis (rapid breakdown of skeletal muscle) without additional cardiovascular benefits.Please consider discontinuing the Fenofibrate and ordering a fasting lipid panel in 4 weeks.There was no documentation of the physician response on the form.Review of Resident #13's physician orders for February 2026 included the medications Atorvastatin Calcium 80 milligrams (mg) give one tablet at bedtime and Fenofibrate 54 mg one tablet daily.Review of the progress notes found no documentation the physician reviewed the recommendations of the pharmacist.On 2/3/2026 at 2:34 p.m., Unit Manager Licensed Practical Nurse Staff I reviewed the Consultant Pharmacist Medication Regimen Review. In an interview she said the Pharmacist Recommendations are given to the Director of Nursing (DON). The DON will send them to the physician. Once they are signed, they are sent back to pharmacy, and we follow the physician order.On 2/3/2026 at 2:46 p.m., in an interview the Advanced Practice Registered Nurse (APRN) said, We review the pharmacy consultant's recommendations, and we sign off on them if we agree with the recommendations. The APRN reviewed Resident #13's clinical record and confirmed the resident was still receiving Atorvastatin Calcium 80 milligrams (mg) one tablet at bedtime and Fenofibrate 54 mg one tablet daily. The APRN said, I can look at her medications and I can discontinue one. We do not order Lipid panels on residents over 80.On 2/3/26 at 2:52 p.m., an interview was held with the DON related to the process to ensure the pharmacy consultant's recommendations are reported to the attending physician and acted upon.The DON verified the pharmacy consultant's Recommendations to the physician for Resident #13 on 10/31/25 were not acted upon. The DON said, I was not here at that time.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility's policy and procedure, staff and resident interviews, the facility failed to ensure the safe storage of medications for 3 (Residents #37, #70, and #74) of 3 residents observed with unsecured medications at the bedside.The findings included:Review of Facility Policy Storage of Medications dated 2001, revised 2020 documented the facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation (1) Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. On 2/2/26 at 11:43 a.m., observation of Resident #37's room revealed a bottle of Milk [NAME] stored on the bedside table. A bottle of Nystatin antifungal powder and a jar of Triamcinolone Acetonide cream were observed on a table in the resident's room. Photographic evidence obtained. On 2/3/26 at 10:15 a.m., Registered Nurse (RN) Staff P observed Resident #37's room and verified the bottle of Milk [NAME], the bottle of Nystatin antifungal powder and the jar of Triamcinolone Acetonide cream were unsecured. RN Staff P reviewed Resident #37's clinical record and said the physician's orders did not include Milk [NAME], Nystatin antifungal powder and Triamcinolone Acetonide cream. On 2/3/26 at 10:28 a.m., and at 3:08 p.m., observation of Resident #37's room revealed the bottle of Milk [NAME], the bottle of Nystatin antifungal powder and the jar of Triamcinolone Acetonide cream remained unsecured at the resident's bedside. On 2/2/26 at 12:02 p.m., observation of Resident #70's room revealed a bottle of Fluticasone Propionate Nasal spray stored at the resident's bedside in a tray. In an interview, Resident #70 said she used the spray when her nose gets stuffy. Photographic evidence obtained. On 2/3/26 at 9:34 a.m., in an interview the Director of Nursing (DON) said Resident #70 was not to have medications at bedside. On 2/2/26 at 10:06 a.m., during the initial tour of facility, a tube of Santyl Ointment (used to remove dead tissue from skin ulcers) and a bottle of sodium hypochlorite solution 0.125% (prescription strength, topical solution used to treat chronic wounds) were observed stored on the resident's nightstand. Photographic evidence obtained On 2/2/26 at 10:21 a.m., in an interview LPN Staff N, said the treatment medications should not be in the resident's room. She said they should be kept in the treatment cart and always locked. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/2/26 at 10:47 a.m., observation of Resident #74's room revealed an Albuterol Sulfate inhaler stored on the resident's overbed table. In an interview, Resident #74 said she keeps the medication in her room and uses it as needed. Photographic evidence obtained. On 2/2/26 at 11:02 a.m., in an interview LPN Staff O verified the Albuterol Sulfate inhaler was unsecured and should be locked in the medication cart.