STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105507	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at North Fort Myers	991 Pondella Rd N FT Myers, FL 33903

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview with the Dietary Manager, the facility failed to store food in an appropriate manner in accordance with guidelines of the FDA (Food and Drugs Administration) Food Code to ensure food was stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. The findings included:The facility policy and procedure titled, Food Storage: Cold Foods, revised 4/2018, policy #019's Policy Statement stated, All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA (Food and Drug Administration) Food Code. Procedures . All food will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination . References : https://www.fda.gov/downloads/food/guidanceregualtions/retailfoodprotection/foodcode/ucm374510.pdf. The undated dietary department policy titled, Labeling and Dating Inservice noted, . Importance of Labeling and Dating. Proper labeling and dating ensures that all foods are stored, rotated, and utilized in a First In First Out (FIFO) manner. This will minimize waste and ensure that items that are passed their due date are discarded. Guidelines for Labeling and Dating . Leftovers must be labeled and dated with the date they are prepared and the use by date.On 4/6/26 at approximately 9:34 a.m., observation of the kitchen with Dietary Manager (DM) during the initial tour of the kitchen revealed:In the beverage refrigerator, the following food items were not dated: 2 egg sandwiches in a clear plastic wrap; 2 facility made salads; and 12 fortified puddings in a bowl with a clear lid. In the walk-in refrigerator: 1 soup-based container-dated 2/26; a jar of grape jelly-dated 2/19, half of a block of margarine/butter which was not dated; a bottle of pancake syrup open and half empty-without a date; 2 bags of shredded cheese-open and undated; and a bag of hash browns-open and undated.In an interview, the Dietary Manager verified that all the food items observed during the initial tour of the kitchen in the beverage refrigerator and walk-in refrigerator were not dated and/or disposed of according to their policy. The Dietary Manager said that all food items prepared by dietary, opened and stored in the kitchen or pantries were required to have an appropriate label indicating what the food was, the date the food was made or opened to ensure they were rotated and used appropriately and/or disposed of as required per their policy and Food Storage and Retention Guide.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interviews, the facility failed to ensure the clinical record of 1 (Resident #11) of 2 residents reviewed for accurate documentation was completely and accurately documented. The findings included: Review of the clinical record for Resident #11 revealed an admission date of 10/31/22.Diagnoses included: Acute gastric ulcer with hemorrhage; Traumatic subdural hemorrhage with loss of consciousness (head injury); Mild protein-calorie malnutrition; Dysphagia (difficulty swallowing); Epilepsy; Cerebrovascular disease (disease of the blood vessels in the brain).Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11scored 14 on the Brief Interview for Mental Status, indicating intact cognition. The MDS noted that Resident #11 required setup or clean-up assistance for eating.Review of the care plan completed on 2/19/26 revealed that Resident #11was at risk for malnutrition related to prior medical history of anxiety disorder, major depressive disorder, chronic obstructive pulmonary disease, gastroesophageal reflux disease, altered laboratory results, need for mechanically altered diet, body mass index of 23, mild protein calorie malnutrition, and Mini Nutritional Assessment score of 8. The goals included consumption of greater than 50-75% of meals/fluids.The approaches included to provide, serve diet as ordered; monitor intake and record every meal.Review of the Mini Nutritional assessment dated [DATE] revealed Resident #11was at risk for malnutrition. The meal intakes were noted to be 50 to 100%, mostly 75-100%. Resident #11's weight was noted at 157 pounds (lbs.) and his Body Mass Index was 21.3, which is considered low.Review of the Certified Nursing Assistants (CNAs) documentation for March 2026, and April 2026 revealed that the meal intake was not documented for 44 of 117 meals.For the breakfast meal, there was no meal intake documented on 3/1, 3/3, 3/4, 3/5, 3/8, 3/10, 3/11, 3/14, 3/16, 3/17, 3/21, 3/22, 3/24, 3/25, 3/28, 3/30, 4/4, 4/5, 4/6, 4/7, and 4/8.For the lunch meal no meal intake was documented on 3/1, 3/3, 3/4, 3/5, 3/7, 3/8, 3/10, 3/11, 3/14, 3/16, 3/17, 3/21, 3/22, 3/24, 3/25, 3/28, 3/30, 4/4, 4/5, 4/6, 4/7, and 4/8.No meal intake was documented for supper on 3/15. On 4/9/26 at 9:15 a.m., in an interview the Director of Nursing (DON) confirmed the CNAs did not document 44 meal percentages as required. The DON said that the CNAs should document meal intake and/or refusals for every meal.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review and staff interviews, the facility failed to ensure fall prevention interventions were implemented for 1 (Resident #53) of 3 residents reviewed who sustained multiple falls at the facility.The findings included:Review of the clinical record of Resident #53 revealed an admission date of 1/26/26. Diagnoses included Chronic Obstructive Pulmonary Disease, Systemic Lupus, unspecified displaced fracture of surgical neck of left humerus, syncope (fainting) and collapse.Review of the 5-Day Minimum Data Set (MDS) Assessment with an assessment reference date of 2/5/26 revealed that Resident #53's cognition was severely impaired. The resident required substantial/maximal assist with toileting, bathing and transfers; partial/moderate assistance with dressing, sit to stand, and bed mobility.A Change in Condition progress note dated 1/27/26 revealed Resident #53 resident had a fall. Nursing staff assisted the resident in getting back to bed. Education provided on fall prevention measures. Resident to call for assistance before getting out of bed/chair when needed.A care plan initiated on 1/27/26 documented that Resident #53 had an actual fall with no injury related to unsteady gait. The goal was for the resident to resume usual activities and minimize the risk of further incident. The intervention was a Physical Therapy consultation for strength and mobility.On 1/28/26, bilateral fall mats were added to the resident's care plan.A Change of Condition Progress Note dated 1/29/26 documented that Resident #53 had a fall. The Change in Condition did not include details of the fall.A physician progress note dated 1/29/26 documented that Resident #53 had another fall where he was found sitting on the side of his bed.On 1/29/26, a scoop mattress (specialized mattress with raised, bolstered sides for fall prevention) was added to the care plan interventions. A Change in Condition dated 1/30/26 documented Resident #53 had a fall. The Change in Condition did not include details of the fall.An Interdisciplinary Team (IDT) note dated 1/30/26 documented that Resident #53 gets anxious at night and attempts to climb out of bed. Resident does not have any trunk control and cannot stand up. Psychiatric evaluation and medication review to be completed.A nursing progress note dated 2/3/26 documented that Resident #53 was observed sitting on the floor by his bed. The resident was unable to report what he was doing at the time of the fall. The care plan was reviewed. Bilateral floor mats in place, scoop mattress to bed.The Certified Nursing Assistant (CNA) Kardex (contains instructions for daily care) did not include the bilateral fall mats interventions under safety for Resident #53.On 4/6/26 at 2:39 p.m., and on 4/7/26 at 8L45 a.m., Resident #53 was observed in bed. The floor mats were observed folded up against the wall.On 4/8/26 at 11:57 a.m., in an interview CNA Staff A said that when Resident #53 was admitted , he was very confused and would fall from bed. She said the resident should always have bilateral floor mats placed on the floor whenever the resident is in bed.On 4/9/26 at 12:41 p.m., Resident #53 was observed in bed. The bed was in high position. The floor mats were folded up against the wall.On 4/9/26 at 12:45 p.m., in an interview the Director of Nursing (DON) said the floor mats should be placed on the floor whenever Resident #53 is in bed. The DON verified that the floor mats were not listed on Resident #53's Kardex due to an error when the care plan was written.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on staff interviews and record review, the facility failed to ensure ongoing communication with the dialysis center related to the ongoing assessment of a dialysis resident before and after each dialysis treatment for 1 (Resident #128) of 1 resident receiving dialysis.The findings included:The facility's policy Coordination of Hemodialysis Services #N1359 with a revision date of 07/02/2019 stated residents which have required an outside ESRD (End Stage Renal Disease) facility will have services coordinated by the facility. There would be communication between the facility and the ESRD facility regarding the residents. A dialysis communication form would be initiated by the facility for any resident going to an ESRD center for hemodialysis. Nursing would collect and complete the information regarding the resident to send to the ESRD center . Upon the resident's return to the facility, nursing will review the dialysis communication form and information completed by the dialysis center or the information sent by the dialysis center. Nursing will complete the post dialysis information on the dialysis communication and file the completed form in the resident's clinical record.Review of Resident #128's medical record revealed an admission date of 3/26/26. Diagnoses included a medical history of ESRD and Chronic Kidney Disease, Stage 5. The admitting physician's orders included hemodialysis services every Tuesday, Thursday and Saturday at the dialysis center.Review of Resident #128's Dialysis Communication Record forms revealed:On 3/14/26, the form did not document if Resident #128 had received medication prior to going to the dialysis center as ordered by the physician, shunt site assessment while at the dialysis center and shunt site assessment upon return from the dialysis center to the facility.On 3/28/26, the form did not document if Resident #128 had received medication prior to going to the dialysis center as ordered by the physician; the assessment of Resident #128's shunt site upon return from the dialysis center was incomplete.On 4/2/26, the form lacked documentation that Resident #128's shunt site was assessed upon return to the facility.On 4/4/26, the dialysis communication information was written on a note pad and only documented pre-dialysis and post-dialysis vital signs and weight. The Dialysis Communication Record form was not completed by facility nursing staff or the Dialysis Center. There was no documentation of the shunt site before, during, or after dialysis.On 4/7/26, the dialysis communication form was missing documentation: if Resident #128 had received medication prior to going to the dialysis center as ordered by the physician, assessment of the shunt site at the Dialysis Center and shunt site assessment upon return from the dialysis center to the facility.An undated Dialysis Communication Record form was incomplete. It did not document if medications were administered prior to dialysis as ordered by the physician, a pre-dialysis or post-dialysis shunt site assessment.On 4/7/26 at 3:42 p.m., Registered Nurse (RN) Staff B reviewed Resident #128's Dialysis Communication Record forms dated 3/14/26, 3/28/26, 4/2/26, 4/4/26, 4/7/26, and the undated Dialysis Communication Record form. She confirmed the Dialysis Communication Record forms were incomplete and did not contain the required documentation. RN Staff B confirmed that Resident #128 received hemodialysis at the dialysis center every Tuesday, Thursday and Saturday. She said the facility nurse who sent Resident #128 to the dialysis center was required to complete the top portion of the Dialysis Communication Record form to include if the resident had received their physician ordered medication prior to leaving the facility, the name of the medication and if the medication was not given as ordered to document on the form why the medication was not administered as per physician orders. She said upon the resident's return from the dialysis center, the receiving nurse was required to review the documentation from the dialysis center and document their post-dialysis assessment of the resident's dialysis shunt site on the bottom portion of the communication form.On 4/7/26 at 4:04 p.m., in an interview Unit Manager Staff C confirmed that the nursing staff who sends the resident to the dialysis center was required to complete the top portion of the Dialysis Communication Record form. The nurse who receives the resident from the dialysis center was responsible to review the Dialysis Communication Record form for any new orders from the dialysis (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	center, conduct and document a full assessment of the resident's dialysis shunt site on the bottom of the Dialysis Communication Record form. Unit Manager Staff C reviewed Resident #128's Dialysis Communication Record forms dated 3/14/26, 3/28/26, 4/2/26, 4/4/26, 4/7/26, and the undated Dialysis Communication Record form and stated they were missing the facility nurses' required documentation as required by the facility's policy.On 4/9/26 at 8:27 a.m., in an interview the Director of Nursing said Resident #128's Dialysis Communication Record forms were not completed as required by their Coordination of Hemodialysis Service Policy and Procedure.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and interviews, the facility failed to have documentation of a performance review and in-service education based on the outcome of the review for 1 (Staff E) of 4 Certified Nursing Assistants (CNAs) reviewed.The findings included:On 4/8/26, review of CNA Staff E's employee file revealed a date of hire of 9/11/24. The employee file lacked documentation of an annual performance evaluation for the year 2025.On 4/8/26 at 2:18 p.m., the Human Resources Director reviewed CNA Staff E's employee file and confirmed in an interview that no annual performance evaluation had been completed since CNA Staff E's original hire date.On 4/9/26 at 8:03 a.m., in an interview, the Nursing Home Administrator verified that CNA Staff E had been employed at the facility since 9/11/24. She said they were unable to find an annual performance evaluation for CNA Staff E.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and staff interviews, the facility failed to have documentation of dementia management training for 2 (Staff E and Staff D) of 4 Certified Nursing Assistants (CNAs) reviewed.The findings included:Review of the CNA Staff E's employee file revealed the Dementia Care: Effective Communication training assigned to the CNA on 9/11/24 had a status of not started.No other annual dementia training was in the employee records.Review of CNA Staff D's employee file revealed the Dementia Care: Effective Communication training was assigned to the CNA on 9/1/23 and had a status of not started. No other annual dementia training was in the employee records.On 4/8/26 at 1:04 p.m., in an interview, the Human Resources Director said that the education transcripts of CNAs Staff D and Staff E did not include dementia training. She verified that CNAs Staff D and Staff E never completed the Dementia Care: Effective Communication training that were assigned to them respectively on 9/1/23 and 9/11/24.On 4/8/26 at 2:20 p.m., in an interview, the Nursing Home Administrator confirmed that CNA Staff D and CNA Staff E had not completed dementia training for 2025.