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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>105551 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY COMPLETED<br><br>08/12/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Aviata at Bradenton |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>105 15th St E<br>Bradenton, FL 34208 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>(continued on next page) |

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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| <p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Based on observation, record review, and interviews, the facility failed to ensure a functioning grievance process for one resident (#2) of four residents reviewed for grievances. Findings included: A review of Resident #2's admission record revealed an admission date of 05/2024 with diagnoses to include but not limited to Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominant side and muscle weakness. On 08/12/2025 at 9:49 a.m., an observation was conducted of Resident #2's room. The light in the hallway above the door was sounding repeatedly with a flashing red light blinking. At 10: 50 a.m., an observation was conducted of Resident #2's room, the light above the door was still flashing and sounding. No residents were in the room at the time of observation. An interview was conducted on 08/12/2025 at 11:01 a.m. with the Social Service Director (SSD). A grievance from Resident #2 was reviewed, dated as received on 07/21/2025: Resident stated his call light was not answered timely on 3pm-11pm shift on 07/18/2025. The findings documented: Explained to resident that call light is malfunctioning and maintenance team are working on getting it fixed. Resident provided with a bell to ring in the meantime. The grievance was documented to have been resolved on 07/22/2025. The form documented the outcome was verbally communicated the outcome of the investigation and the resident was satisfied. During the interview with the SSD, she stated, his call light was dysfunctional. It was staying on continuously. We could not get it to cut off. We gave the residents (in the room) bells to ring during that period. They like to keep them, even though the light is fixed. We offered room changes until that got resolved; and we offered them staff to round more frequently in that room. During the interview on 08/12/2025 at 11:15 a.m., the SSD and the surveyor observed Resident #2's room, the red light above the door was flashing and sounding. Resident #2 was in the room, in his wheelchair, he stated the call bell light had been going off for about a month and a half. he said, They gave me a bell. Sometimes they do not hear it. It can take a while. Bells were observed at Resident #2's bedside and the roommate's bedside, and one on the back of the commode in the bathroom. At this time, the SSD said it was a shock to her; the residents had bells; she thought maintenance was fixing the call lights. On 08/12/2025 at 12:08 p.m., the Maintenance Director was interviewed. He stated for Resident #2's room, We changed the box in the wall, he (the resident) purposely pulled at the box; I have seen him bang it. I could be wrong. I used all the spare parts. For the grievance, there was a whole new box installed in the bathroom at the time the grievance was done. The Maintenance Director reported the continuous sounding of the light in the hall stopped at that time, it worked for about a week and then started up again. He stated he was waiting for a technician from an electric company to come to the facility to bring spare parts. When asked how long it took for the electric company to respond to a request from him, he stated, It takes about a week, sometime 2-3 days. When asked if he had any documentation to support the effort by the facility to resolve the resident's concern regarding the continuous call bell light, he did not respond. He stated he would call today. On 08/12/2025 at 3:40 p.m. a telephone interview was conducted with Resident #2's family member. He stated he would visit the resident all the time. He worked around the corner from the facility and will come in at various times. He stated the call bell light has been going off continuously for weeks. The family member said, I could understand if it were a couple to a few days, but it had been a month. They should have fixed it. The family member stated the resident has to wait for help. They had given him a bell to ring. The family member stated sometimes the staff do not hear it and reported having to go into the hall to ring the bell for them to hear it. The family member stated, I do his laundry; his clothing is soiled. They are not getting to him quick enough. I talked to Maintenance and the Nursing Home Administrator. A review of the facility's policies and procedures for Complaint/ Grievance, N-1042, last revised 10/24/2022, documented the policy: The Center will support each resident's right to vice a complaint/ grievance without fear of discrimination or reprisal. The center will make prompt efforts to resolve the complaint; Grievance and informed (sic) the resident of progress towards resolution. The procedure included: .4. The grievance follow-up should be completed in a reasonable time frame; this should not exceed 14 days.</p> |   |  |

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| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>(continued on next page)</p> |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Based on observation, record review, and interviews, the facility failed to ensure timely and consistent incontinence services were provided for three residents (#3, #4, and #2) of four residents sampled for incontinence care. Findings included: 1. Review of Resident #3's admission Record revealed an admission date of 10/2022 with diagnoses to include Chronic kidney disease, Stage 3 unspecified, overactive bladder, unspecified dementia, muscle weakness (generalized) and essential (primary) hypertension. A review of a social services progress note dated 12/17/2024 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. A review of Resident #3's Care Plan, documented a focus area for ADL (Activity of Daily Living) self-care deficits, . Decline from prior level of functioning, needs assistance with self-performance, bed mobility, transfers, dressing, eating, toilet use, personal hygiene, oral hygiene, and bathing, initiated 04/15/2022. The interventions included: Toilet Use - I require extensive assist by one staff for toileting. Transfer - I require supervision with transfers. A review of Resident #3's progress notes revealed the following: On 07/24/2025 at 9:15 a.m., Staff A, Registered Nurse, (RN) documented a skin note: Skin observation complete and new MASD (moisture-associated skin damage) noted to Inner Buttocks crease. (Medical Doctor) notified and new order received for skin TX (treatment). On 07/25/2025 at 5:07 p.m., Staff A, RN documented, Resident started on PO (by mouth) ABT (antibiotic) for abnormal urine results. On 07/27/2025, a note documented by the Nurse Practitioner showed, The patient has been seen at the bedside. The patient was lying in bed. Staff noticed an open area on the right gluteal fold, during the skin checks. On assessment the (sic) is an open area on the right gluteal fold (a horizontal crease on the inferior aspect of the buttocks and the posterior upper thigh) noted, has no drainage or odor noted it is consistent with moisture-associated skin damage (MASD). New order was initiated for zinc oxide cream application with every brief change and as needed. The patient is to be repositioned every two hours as tolerated to aid in prevention of further skin breakdown. A review of Resident #3's ADL documentation for Toileting Hygiene for the dates of 07/18/2025, through 07/27/2025, a ten-day period, reflected the following documented assistance for Toileting Hygiene: Three of the 10 days, 07/19, 07/21, and 07/24, staff documented providing toileting services once during the 24-hour period. Three of the 10 days, 07/18, 07/20, and 07/22, staff documented providing toileting services two times during the 24-hour period. The other 4 dates, 07/23, 07/25, 07/26, and 07/27, staff documented providing toileting services three times during the 24-hour period. On 08/12/2025 at 1:51 p.m., an interview was conducted with Assistant Director of Nursing (ADON) regarding Resident #3's ADL documentation for toileting/ hygiene. During the review, she stated she could provide better documentation, she stated she was not familiar with the presented documentation. She confirmed it looked like documentation was lacking. On 08/12/2025 at 2:50 p.m., an interview was conducted with the Nursing Home Administrator (NHA), she stated she wanted to clarify what was needed for the ADL documentation. A review of the Toileting Hygiene documentation provided for Resident #3 was conducted with her. She stated, I know the care is being provided, the staff are not documenting. Subsequently, at approximately 3:20 p.m., the NHA, she provided a 2nd set of ADL paperwork. She could not decipher the code; she said, Let me get the unit manager; they review the documentation. On 08/12/2025 at 3:51 p.m. An interview was conducted with Staff B, Licensed Practical Nurse (LPN) with the NHA in the room. She reviewed the ADL documentation. She stated, you should see documentation every shift. She stated her monitoring of the ADL documentation was, she would receive an alert if the resident had not had a bowel movement or urinated within three days, Nothing further. Staff B stated she had been familiar with Resident #3, the resident was not on her unit but would come over and need to be redirected to the other side; Staff B stated she would have an incontinent episode. You could see the urine/ damp clothes and staff would have to change her frequently. On 08/12/2025 at 5:00 p.m., the NHA returned with the Minimum Data Set Coordinator (MDS), RN. She provided additional forms for ADL assistance; The forms were reviewed with both of them and reflected no additional information. The MDS/RN stated there was an issue with documentation. 2. A review of Resident #4's admission Record documented admission in 06/2021 with diagnoses including but not limited to; muscle weakness, Chronic Obstructive Pulmonary disease, chronic kidney disease, and unspecified dementia. A review of a social services progress note dated 11/04/2024 revealed Resident #4 had a BIMS score of 4, which indicated severe cognitive impairment. A review of Resident #4's care plan revealed a focus area for the resident being at risk for urinary incontinence due to overactive bladder and BPH (Benign Prostatic Hypertrophy) with an intervention: Clean</p> |   |  |

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| <p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Keep all essential equipment working safely.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a timely repair of a call bell light for one resident (#2) of five sampled residents. Findings included: On 08/12/2025 at 9:49 a.m., an observation was conducted of Resident #2's room. The light in the hallway above the door was sounding repeatedly with a flashing red light blinking. At 10: 50 a.m., the light above Resident #2's door was observed still flashing and sounding. No residents were in the room at the time of observation. Resident #2's call bell light was identified to blink and sound continuously on 07/21/2025 and the light was still malfunctioning as of 08/12/2025. On 08/12/2025 at 11:01 a.m. a grievance from Resident #2 was reviewed with the Social Service Director (SSD). Resident #2's grievance was dated as received on 07/21/2025 with a resolution date of 07/22/2025. The concern in the grievance, Resident stated his call light was not answered timely on 3 p.m. -11 p.m. shift on 07/18/2025. The findings documented: Explained to resident that call light is malfunctioning and maintenance team are working on getting it fixed. Resident provided with a bell to ring in the meantime. During the interview with the SSD, she stated, his call light was dysfunctional. It was staying on continuously. We could not get it to cut off. We gave the residents (in the room) bells to ring during that period. They like to keep them, even though the light is fixed. We offered room changes until that got resolved; and we offered them staff to round more frequently in that room. On 08/12/2025 at 11:15 a.m., Resident #2's room was observed with the SSD present. The red light above the door was flashing and sounding. Resident #2 was in the room, in his wheelchair, he stated the call bell light had been going off for about a month and a half. Resident #2 stated, They gave me a bell. Sometimes they do not hear it. It can take a while. Bells were observed at Resident #2's bedside and the roommate's bedside, and one on the back of the commode in the bathroom. At this time, the SSD said it was a shock to her; the residents had bells; she stated she thought maintenance was fixing it. On 08/12/2025 at 3:40 p.m. a telephone interview was conducted with Resident #2's family member. He stated he would visit (Resident #2) all the time. He worked around the corner from the facility and will come in at various times. He stated the call bell light had been going off continuously for weeks. The family member said, I could understand if it were a couple to a few days, but it had been a month. They should have fixed it. He stated my (Resident #2) has to wait for help. They had given him a bell to ring. Sometimes the staff do not hear it. (Resident #2) will have to go into the hall to ring the bell for them to hear it. I do his laundry; (Resident #2's) clothing is soiled. They are not getting to him quick enough. I talked to Maintenance; I talked to the Nursing Home Administrator. On 08/12/2025 at 12:08 p.m., the Maintenance Director was interviewed. He stated for Resident #2's room, We changed the box in the wall, he (the resident) purposely pulled at the box; I have seen him bang it. I could be wrong. I used all the spare parts. For the grievance, there was a whole new box installed in the bathroom at the time the grievance was done. The Maintenance Director reported the continuous sounding of the light in the hall stopped at that time, and it worked for about a week and then started up again. He stated he was waiting for a technician from an electric company to come to the facility to bring spare parts. When asked how long it took for the electric company to respond to a request from him, he stated, It takes about a week, sometime 2-3 days. When asked if he had any documentation to support the effort by the facility to resolve the resident's concern regarding the continuous call bell light, he did not respond. He stated he would call today. On 08/12/2025 at 1:15 p.m., an interview was conducted with the Maintenance Director who stated he had two methods of receiving work orders from the staff, the (electronic work order) system and a binder at the nurses' station. He stated there was no order in either places for (Resident #2's) call bell light not functioning. The Maintenance Director said, I just walk by and fix it.</p> |   |  |