STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105551	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Bradenton	105 15th St E 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interviews, the facility failed to ensure documentation was complete and accurate related to physician orders for catheter care for one (Resident #1) out of five residents reviewed. Findings included: A review of Resident #1's admission record revealed an original admission date of 9/23/25 and re-admission date of 2/28/26, with diagnoses to include hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, personal history of urinary (tract) infections, encounter for fitting and adjustment of urinary device, and other neuromuscular dysfunction of bladder. A review of Resident #1's active, completed and discontinued physician orders from 1/2026 to 3/2026 revealed the following: BEHAVIORS - MONITOR FOR THE FOLLOWING: . Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and document findings and interventions. every shift, with a start date of 3/1/26. Catheter Care as Needed as needed, with a start date of 3/1/26. Catheter Care as Needed every shift, with a start date of 3/1/26. CHANGE FOLEY one time only until 1/29/26 23:59 [11:58 p.m.], with a start and end date of 1/29/26. EMPTY FOLEY BAG RECORD OUTPUT every shift, with a start date of 3/3/26. Foley Catheter (16F [French] 10CC [cubic centimeter] BALLOON), with an order date of 2/28/26. A review of Resident #1's care plan revealed the following: [Resident #1] has Indwelling Catheter: Neurogenic bladder Date Initiated: 10/06/2025, with interventions to include, CATHETER: Cath [catheter] care as ordered. CATHETER: The resident has (foley Catheter). Monitor for s/sx [signs and symptoms] of discomfort on urination and frequency. Monitor/document for pain/discomfort due to catheter. Monitor/record/report to MD [medical doctor] for s/sx UTI [urinary tract infection]: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp [temperature], Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. A review of Resident #1's medication administration record (MAR) revealed the following:January 2026 the following order was documented, Change Foley Catheter 16F/10cc [cubic centimeter] on 15th of every month and as needed every night shift starting on the 15th and ending on the 15th every month for Catheter Care -Start Date- 01/15/2026 1900 [7:00 p.m.]-D/C [discontinue] Date- 02/27/2026 1122. Further review of the MAR revealed a blank space on 1/15/26 for this order. February 2026, under behavior monitoring documentation, entries on all days were marked as, No, except for 2/4/26 and 2/11/26 were marked as, Yes. A review of the progress notes on the days marked, No, for behaviors did not indicate the behavior Resident #1 was having. Further review of the MAR in February 2026 showed on 2/15/26, Staff B, Licensed Practical Nurse (LPN) changed Resident #1's catheter after it was changed on 2/12/26 by Staff A, LPN, which was also marked on the MAR.March 2026, the order for, EMPTY FOLEY BAG RECORD OUTPUT every shift showed, y was documented on 3/6/26 (day shift), 3/7/26 (night shift), and 3/9/26 (night shift). Further review of the order showed on 3/18/26 it was blank for the day shift and, NA, [not applicable] was documented for the night shift. A review of Resident #1's progress notes showed the following:1/29/26, Resident Foley catheter was changed and tolerated well the insertion. clear light yellow urine output noted.2/12/26, Change Foley Catheter 16F/10cc on 15th of every month and as needed as needed for catheter care.2/13/26, Change Foley Catheter 16F/10cc on 15th of every month and as needed as (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed for catheter care PRN [as needed] Administration was: Effective. A review of Resident #1's progress notes dated 1/15/26 showed no documentation related to changing Resident #1's catheter. The resident had orders to change the catheter every 15th of the month and as needed. Further review of Resident #1's progress showed no documentation related to the rationale for changing the catheter on 2/12/26, then changed again on 2/15/26. On 3/23/26 at 1:10 p.m., an interview was conducted with the Director of Nursing (DON). He said the facility staff did not previously document a resident's input and output. He stated, There was an incident with [Resident #1], and the nursing staff are supposed to document the urine output based on the physician order. He confirmed there is a physician order, and the output should be documented in the MAR. On 3/23/26 at 1:20 p.m., a telephone interview was conducted with Staff A, LPN. She said catheter care included documenting the resident's output on a daily. Staff A, LPN confirmed she had changed Resident #1's catheter but could not recall the date of when she changed it or the reason why it was changed. She said she did not have the computer in front of her and could not confirm the information asked. On 3/23/26 at 1:31 p.m., a telephone interview was conducted with Staff B, LPN. She initially said she did not change Resident #1's catheter as it was not on her shift assignment. A review of the MAR in 2/2026 was conducted while on the telephone with Staff B, LPN, who then said she recalled changing it. Staff B, LPN said another nurse was present as the resident required two staff members to assist with care. She said she could not recall why Resident #1's catheter was changed on 2/12/26, then again on 2/15/26. On 3/23/26 at 3:37 p.m., a follow-up interview was conducted with the DON. He confirmed in the MAR on 3/6/26, 3/7/26, and 3/9/26, the y that was documented was incorrect. He stated the order is, Asking for amount of cc, not if it was emptied. He said if the output was not documented in the MAR or Treatment Administration Record (TAR), he expected it would be documented in a progress note. A review of the progress notes with the DON revealed there was no documentation on those dates. The DON said he was not sure what, NA, meant but it should not be documented. He stated the Order is pretty clear, and asked for urine output in ccs. He said staff were educated about what to document in the MAR. The DON confirmed Resident #1's catheter should have been changed on 1/15/26 if the order was for the 15th of every month. He said if it was not changed on 1/15/26, there should have been documentation, as to why not. He said he did not know why it was not changed on 1/15/26 and confirmed he reviewed the documentation which showed Resident #1's catheter was changed on 1/29/26. The DON said he knew it was changed on 1/29/26 from the progress note, but the documentation did not provide a reason for why it was completed that day. The DON stated on 2/15/26 he, Figured they followed the order. He stated he, Did not speculate on that. He confirmed the catheter was changed on 2/12/26 then changed again on 2/15/26 based on the MAR. He stated, If the nurse did not dig into why, or did not receive information in the nurse-to-nurse report, the nurse would not have known it was changed on 2/12/26. The DON said there had been confusion about the behavior monitoring order and staff would need to be re-educated. He said the order showed to indicate, Yes, if the resident had no behaviors and, No, if they had behaviors and the specific behavior should be documented in a progress note. He said under the previous company/ownership, the order allowed the staff to choose the behavior observed. He said he thought that was why staff continued to document, No, for behaviors. A review of the facility's policy titled Catheter Care, Urinary, with a revised date of 9/5/17, revealed the following, Procedure:Identify resident.Provide privacy and explain procedure.Assemble the following:Towel and wash clothSoapBasin of warm waterDisposable gloves Perform hand hygiene.Put on gloves.Remove catheter securement device while maintaining connection with drainage tube.Wash perineal area with soap and water from front to back.Rinse well and dry.Clean Catheter tubing with soap and water, starting close to urinary meatus, cleaning in circular motion along its length for about 4 inches, moving away from the body. Rinse well using the same motion.May use incontinent wipes in place of soap and water.Reattach catheter securement device.Return equipment to proper place. Perform hand hygiene. A review of the facility's policy titled Physician Orders, with a revised date of 3/3/21, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the following, ROUTINE ORDERS: . The order is transcribed to all appropriate areas of the electronic health record (eMar/eTAR) [electronic treatment administration record]. The ordering physician or physician extender will review and confirm orders. Confirmation of routine orders requires that the physician sign and date the order as soon as practicable after it is provided to maintain an accurate medical record.