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	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Bradenton	105 15th St E Bradenton, FL 34208

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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 observations, record review, interviews, and policy review, the facility failed to ensure kitchen sanitation requirements were met, due to kitchen walls had non-cleanable surfaces, and failed to ensure items in the kitchen pantry and walk-in refrigerator were dated, for one out of one walk-in refrigerators and one of one kitchen pantries.Findings Included:On 01/12/2026 at 10:15 AM, a kitchen tour was conducted with the District Manager of Dining, (DMD). The kitchen dishwasher was observed soiled with debris, build-up and corrosion on the motor and overhead hood of the dishwasher. The motor was observed with brown colored corrosion expanding from the base of the dishwasher motor. A white powdered material and white build-up was observed on the motor in various areas. The motor was observed with smudges. The metal counter next to the dishwasher was observed with corrosion on the legs of the counter. [NAME] pipes to the left of the dishwasher under the metal counter were observed with brown buildup near where one of the pipes entered a hole in the floor and surrounding areas. The floor under the dishwasher was observed with black, white, gray, and tan debris and build-up on in multiple locations. A small black tub was observed under the metal counter about half-way full of a transparent liquid. The wall behind the metal counter was observed in disrepair with holes in three locations.On 01/12/2026 at 10:20 AM, during a tour with the DMD of the kitchen chemical room, the outside wall of the chemical room was observed with a square hole in the bottom left corner where the wall met the floor, approximately 4 inches in size. The drywall of the hole was observed crumbling and the tile was missing and broken. The inside of the wall was visible. The chemical room revealed a faucet above a floor sink, closed, that actively leaked water. Live flying insects were observed in chemical room. The floor sink was observed discolored with tan and brown stains on the inside of the sink. The floor sink was observed with black streaks and build-up on, around, and in the floor sink.On 01/12/2026 at 10:38 AM, during a tour with the DMD of the kitchen freezer, a beige and light brown cake covered half of a cardboard plate it was on. The cake was wrapped in a plastic bag undated. The DMD confirmed the cake was undated.On 01/14/2026 at 12:03 PM, during a tour with the DMD of the kitchen pantry, a bag of brown sugar was observed wrapped in plastic and undated. About half of the contents remained. A clear bottle of a yellow food coloring was observed opened and undated. About half of the contents remained. The DMD confirmed the bag of brown sugar and the bottle of yellow food coloring had been opened and undated.On 01/14/2026 at 12:34 PM, during a tour with the DMD of the South Wing nourishment pantry, the refrigerator was observed with two thermometers that showed the refrigerator temperature was over 50 degrees. The temperature was confirmed by the DMD. In the refrigerator, there were unknown food items labeled with no resident names or room numbers. The DMD confirmed the unknown food items belonged to residents.During an interview on 01/12/2026 at 10:15 AM, the DMD stated having saw corrosion on the dishwasher's hood vent. The DMD stated having seen a hole in the lower left corner of the chemical room outside wall. The DMD attempted to turn off a faucet in the chemical room and stated the faucet had a leak and was unable to shut off the valve. The DMD stated not knowing the cleaning schedule of the kitchen. The DMD stated not knowing when and how often the kitchen had been cleaned. The DMD was unable to provide cleaning logs for the kitchen. The DMD stated the kitchen (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	should have been cleaned and did not know the last time a deep cleaning had been performed on the kitchen.During an interview on 01/14/2026 at 11:35 AM the DMD stated the kitchen staff was responsible to ensure the kitchen was cleaned. The DMD stated there were undated food items in the walk-in refrigerator and freezer. The DMD stated not knowing why the refrigerator temperature in the South nourishment pantry room, was at 55 degrees. The DMD stated the food in the nourishment room refrigerator belonged to residents.During an interview on 01/14/2026 at 02:00 PM, Staff H Registered Nurse (RN), Unit Manager (UM) of the South wing, stated she was responsible for temperature log monitoring of the South wing nourishment room pantry refrigerator. Staff H stated not being aware of the refrigerator not working properly.During an interview on 01/15/2026 at 06:47 PM, the Nursing Home Administrator (NHA) and Regional [NAME] President (RVP), stated there were expectations for weekly and daily cleaning. The NHA stated the kitchen walls should not be in disrepair. The NHA stated drains should be cleaned, corroded items replaced, and general expectations for areas of the kitchen were to be clean.Record review of the facility's policy titled, Environment, dated 06/2025, showed:Environment Policy StatementAll food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. Procedures 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation.2. The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces.4. The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces.5. All dining areas will be cleaned and sanitized after each use, including tables, chairs, and floors. Photographic evidence obtained.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations and interviews, the facility failed to ensure the kitchen was free from pest in one out of three pantries observed.Findings include: On 01/12/2026 at 10:15 AM, a tour of the facility kitchen was conducted with the District Manager of Dining (DMD). During the tour, live insects were observed flying in the dishwasher room.On 01/14/2026 at 11:35 AM, during a tour of the facility the DMD moved an equipment cart in the kitchen near the eye washing station and a swarm of live insects flew up from the cart. A small clear plastic organizer the DMD referred to as a caddy was observed in the kitchen pantry with honey-like sticky substances, yellow in color. The yellow substances were observed in multiple areas of the caddy, including plastic drawers. The drawers and face of the caddy were observed with black, red, and tan debris. Live insects were observed flying and resting on shelves in the kitchen pantry. The DMD stated we should not have flies in the kitchen pantry. During an interview on 01/14/2026 at 02:26 PM, the DMD stated not knowing if the kitchen had ongoing pest control and monitoring. A request for a pest policy was made and not provided.Record review of the facility's vendor pest control logs revealed for the months of 11/2025 and 12/2025, the facility did not treat for flies.During an interview on 01/15/2026 at 06:47 PM, with the Regional [NAME] President (RVP) the Nursing Home Administrator (NHA), stated not knowing live flying insects were in the kitchen. The NHA stated having expectations of no pest in the kitchen. The RVP stated there was no pest control policy.Photographic evidence obtained.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, interview and record review, the facility failed to ensure resident equipment was maintained and sanitary to include resident room air conditioner unit filters in two of two nursing units. Findings included: On 1/12/2026 at 10:30 a.m., 1/13/2026 at 9:45 a.m. and on 1/14/2026 at 8:50 a.m. during resident room tour, the following resident room wall mounted Packaged Terminal Air Conditioner (PTAC) units were observed for maintenance and cleanliness. It was found the air filters were heavily caked with dust and debris in resident rooms; 201, 204, 206, 207, 209, 210, 211, 212, 213, 214, 302, 303, 304, 306, 311, 104, 106, 109, 110, 115, 119, 121, 122, 127, 131. On 1/15/2026 at 8:45 a.m. an interview with the housekeeping director revealed she and the staff are responsible for cleaning resident spaces to include floors, walls, beds, bathrooms, trash, and windows. Rooms are also deep cleaned per a schedule. The housekeeping director confirmed resident rooms had Air Conditioning units, but the staff are not responsible for the cleaning and maintaining of the air filters. She revealed if the department observed something wrong with the unit, or saw that it needed maintenance, the issue would be brought to the attention of the Maintenance Director either verbally or by way of work order. She has not observed any air conditioning unit air filters and didn't know where they were located on the units. On 1/15/2026 at 10:45 a.m. an interview with the Maintenance Director (DOM) occurred. The DOM said each resident room has a wall mounted Package Terminal Air Conditioner (PTAC) air conditioning/heating unit. He said residents and/or staff could adjust the room temperature by way of the unit. The DOM said each unit has two air filters that should be cleaned and maintained. He said the routine maintenance and cleaning of the filters for each unit should be within a one-month timeframe. The DOM said the electronic maintenance system has a longer timeframe, but he and the staff try to conduct cleaning of air filters monthly. He said his staff had cleaned some filters yesterday but was unsure which ones were cleaned. At 10:57 a.m. the DOM provided the last three months (1/2026, 12/2025, and 11/2025) monthly PTAC unit maintenance and air filter cleaning sheets for review. The documentation only revealed the month the filters were cleaned and not the specific date. The Maintenance Director was provided with photographic evidence of the soiled filters that were noted on 1/12/2026, 1/13/2026, and 1/14/2026. He confirmed the filters should have been cleaned more frequently. On 1/15/2026 at 4:00 p.m. the Nursing Home Administrator provided the Maintenance policy and procedure, with a last revision date 12/20/2023 for review. The policy revealed; Policy - The facility's physical plant and equipment will be maintained through a program of preventative maintenance and prompt action to identify areas/items in need of repair. Procedure - The Director of Environmental Services will follow all polices regarding routine periodic maintenance. The Director of Environmental Services will perform daily rounds of the building to ensure the planet is free from hazards and in proper physical condition. Photographic Evidence Obtained

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate Preadmission Screening and Resident Review (PASRR) Level I screening was completed prior to admission for four (#10, 21, 41, and 91) of the five residents reviewed.Findings include: Review of the admission record showed Resident #10 was admitted to the facility on [DATE], diagnoses including major depressive disorder, anxiety disorder, and schizoaffective disorder of the bipolar type. The resident was also diagnosed with Parkinsonism on 7/26/2024. Review of a level I PASRR for Resident #10 dated 11/21/2024 revealed qualifying diagnoses for Serious Mental Illness (SMI) and/or Mental Illness (MI), and a level II was not submitted for consideration. Review of the admission record showed Resident #21 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Parkinsonism, mood disorder, psychotic disorder, dementia, anxiety, depression, and neurocognitive disorder with Lewy Bodies. Review of level I PASRR for Resident #21 dated 2/26/25 revealed qualifying diagnoses for SMI/MI, and a level II was not submitted for consideration. Review of the admission record showed Resident #91 was admitted to the facility on [DATE] diagnoses including bipolar disorder, anxiety and depression. Review of level I PASRR for Resident #91 dated 11/20/24 revealed qualifying diagnoses for SMI/MI, and a level II was not submitted for consideration. Review of the admission record showed Resident #41 was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including dementia, major depressive and mood disorder. Review of level I PASRR for Resident #41 dated 1/13/26 revealed, the primary diagnosis of dementia is not checked. The review showed the Level I PASRR is inaccurate and a level II was not submitted for consideration with the qualifying diagnoses. During an interview on 1/14/26 at 9:28 a.m. with Staff F, Registered Nurse (RN)/ Minimum Data Set (MDS) nurse and Staff G, Licensed Practical Nurse (LPN)/MDS nurse. Staff F, RN, MDS she was instructed if the resident is not having symptoms, submission for a Level II PASRR is not needed. Review of the facility's policy titled, Subject: Preadmission Screening and Resident Review (PASRR), revised: 11/08/2021 showed the following: Policy: The center will assure that all Serious Mentally Ill (SMI) and Intellectually Disabled (ID) residents receive appropriate pre-admission screenings according to Federal/State guidelines. The purpose is to ensure that the residents with SMI or are ID receive the care and services they need in the most appropriate setting. Procedure: (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. It is the responsibility of the center to assess and assure that the appropriate preadmission screenings, either Level I or Level II, are conducted and results obtained prior to admission and placed in the appropriate section of the resident's medical record. 2. If an individual is declared exempt from a PASRR screening, the Center should make sure that appropriate documentation is on the chart upon admission. Individuals who are exempted from this assessment include: a. Those who are admitted after a release from an acute care hospital for a period not to exceed 30 days as part of a medically prescribed period of recovery. b. Those who are certified by a physician as to be terminally ill with a 6-month prognosis, and are not a danger to self or others. c. Those who are comatose, ventilator dependent, functions at significantly disabling Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis, CHF or COPD. d. Those with a diagnosis of dementia or its related disorders with detailed documentation supporting this diagnosis. 3. There are no exceptions for Intellectually Disabled (ID) screenings. 4. If it is learned after admission that a PASRR Level II screening is indicated, it will be the responsibility of Social Services to coordinate and/or inform the appropriate agency to conduct the screening and obtain the results. 5. Results of the screening evaluation will be placed in the appropriate section of the individual's medical records and any recommendations for services will be followed. 6. Recommendations will be incorporated in the individual resident's plan of care and approaches/interventions developed to meet the identified needs of the individual. 7. Social Services will be responsible for coordinating significant change updates of these screenings, conducted by the appropriate agency. These results, along with the results from the previous years will be kept in the appropriate sections of the resident's record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an effective infection prevention program related to offering hand hygiene prior to eating for one of one dining room observed and proper storage for respiratory items for eight (#1, #16, #27, #50, #64, #72, #102, and #117) of eight residents sampled.Findings include: An observation of Resident #117's room on 1/12/2026 at 9:30 A.M. revealed an oxygen mask on the floor. A record review of Resident #117's record dated 1/15/2026 resident has no orders for oxygen or nebulizer. During an interview on 1/12/2026 at 10:00 A.M. the Staff D, Unit Manager (UM) stated she was unsure how the mask was on the floor of Resident #117 room but said sometimes the resident gets visitors from other residents with oxygen. An observation of Resident #27 on 1/12/2026 at 9:57 A.M. revealed a nebulizer mask uncovered. Review of Resident #27 admission record revealed a diagnosis of dependence on supplemental oxygen onset date of 2/12/2025. A Review of Resident #27 record of Order Summary Report dated 1/15/2026 at 5:53 P.M. showed an active order start date of 7/31/2025 for nebulizer. An order from the pharmacy dated 8/22/2025 for Budesonide Inhalation Suspension one vial inhale orally via nebulizer two times a day and an order dated 7/12/2025 for Ipratropium-Albuterol for quantity of one vial inhale orally two times a day. An observation of Resident #102 room on 1/12/2026 at 10:02 A.M. revealed a nebulizer mask left at the bedside uncovered. Review of Resident #102 admission record revealed a diagnosis of dependence on supplemental oxygen onset date of 05/21/2025. Review of Resident #102 Order Summary Report dated 1/15/2026 revealed an order that started on 8/06/2025 that said to change O2 tubing weekly when in use and an order for nebulizer use that started on 5/22/2025. Review of Pharmacy orders showed Resident #102 had an active order that started on 6/13/2025 for Albuterol to be administered with use of nebulizer for treatment. Review of the facility policy titled Oxygen Masks, Partial Rebreathing, dated 11/30/2014 revealed labeled tubing with date and time. Photographic evidence obtained. 2. On 1/12/2026 at 12:45 P.M. during observation of the lunch meal service in the 100 unit, observed staff started passing trays to the residents. The residents were not offered assistance with hand hygiene. An interview was conducted with Staff Q, Certified Nursing Assistant (CNA) on 1/12/2026 at 12:55 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m. Staff Q stated that the staff do not usually offer to wash the residents' hands or offer any type of hand hygiene. An interview was conducted with the Director of Nursing (DON) on 1/12/2026 at 12:59 P.M. The DON stated that the facility used to have hand wipes but does not know of any now. The DON stated hand hygiene should be offered to the residents prior to meals. An interview was conducted with the Infection Preventionist (IP) on 1/15/26 at 9:08 A.M. The IP stated she was aware hand hygiene was not being provided to residents before meals are served. The IP said the facility has started providing mini hand sanitizers to each staff so that they can offer hand hygiene to the residents. On 1/12/2026 at10:02 A.M., Resident #16's nebulizer tubing on the floor, dated 1/4/2026. Photographic evidence taken of the nebulizer equipment and nasal cannula tubing date. An interview was conducted with the DON on 1/14/2026 at 10:40 A.M. The DON stated the facility changes oxygen tubing every Sunday. He stated the oxygen tubing date was not charted correctly. Review of admission Records showed Resident #16 was admitted to the facility on [DATE] with diagnoses including but are not limited to acute on chronic diastolic heart failure, generalized muscle weakness, chronic respiratory failure with hypercapnia, need for assistance with personal care, and other abnormalities of gait and mobility. 3. During an observation and interview on 1/12/25 at 9:29 A.M., Resident #50's wheelchair was stored in a shared bathroom with an uncovered nasal canula tubing with cream-colored prongs was wrapped around the wheelchair push bar. A review of Resident #51's admission record revealed initial admission on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD) and dependence supplemental oxygen. During an observation and interview on 1/12/25 at 9:29 A.M., Resident #72 had an uncovered nebulizer mask on top of the bedside table. Review of Resident #72's admission record revealed admission to the facility on 1/29/25 with diagnoses including chronic obstructive pulmonary disease (COPD), chronic bronchitis and obstructive sleep apnea. During a medication administration observation on 1/12/25 at 8:24 A.M., with Staff M, Respiratory Therapist (RT) Resident #1 was sitting on the side of her bed. There were uncovered nebulizer and Continuous Positive Airway Pressure (CPAP) masks on top of the bedside table. Staff M, RT stated the items should be bagged and covered when not in use. A review of Resident #1's admission record revealed initial admission on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), chronic respiratory failure, and obstructive sleep apnea. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Photographic Evidence Obtained). During an interview on 1/13/26 at 10:52 A.M. Staff U, Certified Nursing Assistant (CNA), said she places oxygen supplies in a bag for infection control and does not know why the items were not in bags. A review of facility policy and procedure titled, Infection Control, revised October 2018 revealed the following: Policy Statement: This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Policy Interpretation and Implementation: 1. This facility's infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteer workers, and die regardless of race, color, creed, national origin, religion, age, sex, handicap, marital or veteran status, or payor source. 2. The objectives of our infection control policies and practices are to: 2a.Prevent, detect, investigate, and control infections in the facility; 2b. b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors and the general public .4. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how find and use pertinent procedures and related infection control. The depth of employee training shall be to the degree of direct resident contact and job responsibilities. A review of a facility policy and procedure titled, Nebulizer (small volume nebulizer), revision on 3/20/2028 revealed the following: Note-Small volume nebulizers are used to deliver medication aerosols to the respiratory tract to relieve bronchospasm, to deliver medications, to improve the effectiveness of the cough and to relieve mucosa edema. Small volume nebulizers create a mist from a liquid medication solution that can be inhaled into the bronchial tree. Droplets of mist are delivered through a facemask or mouthpiece and absorbed into the bloodstream through alveoli within lung tissue. Procedures: Disassemble device and rinse the mouthpiece and nebulizer cup with water and air dry. Place entire unit in a bag to be maintained in the resident's room.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop care plans with problem areas and interventions related to discharge planning for one (#8. of three sampled residents. Findings included: On 1/12/2026 at 11:15 a.m. Resident #8's room was visited and he was noted seated on side of bed and was dressed for the day. Resident #8 revealed he was at the facility for either long term care services or rehabilitation services. He further commented he believed he was at the facility for short term, but nobody has spoken to him about any type of discharge planning. He revealed his desire was to complete rehabilitation services and possibly move into an Assisted Living Facility, but did know when that would happen. He could not remember anyone speaking to him with relation to discharge planning. Review of Resident #8's medical record revealed he was admitted to the facility on [DATE] for Rehabilitation short term care. Review of the advance directives revealed Resident #8 was his own responsible party. Review of the current Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed; (Cognition/Brief Interview Mental Status or BIMS score - 15 of 15); (ADL - Independent with most to all ADL tasks). Review of the current care plans with a next review date 4/13/2026 revealed no problem areas with goals and interventions to include discharge planning. There were no care plan problem areas related to discharge planning. It was determined Resident #8 was admitted to the facility for almost four months and there was no documentation in the chart related to discharge planning, nor was there any care plans speaking of discharge planning. On 1/15/2026 at 8:50 a.m. both the MDS Coordinator and Care Plan Coordinator were interviewed related to Resident #8.The MDS Coordinator and Care Plan Coordinator revealed Resident #8 was admitted to the facility on [DATE] for short term care initially. The MDS Coordinator and Care Plan Coordinator further revealed he was looking to at some point discharge to an Assisted Living Facility, per his plan. The MDS Coordinator and Care Plan Coordinator both confirmed there was not a current care plan problem area to identify his discharge planning with interventions. The Care Plan Coordinator revealed there are different departments that handle some care plan problem areas and believed Social Services handled the discharge planning care plan.The Care Plan Coordinator and MDS Coordinator both confirmed there should have been a care plan problem area to reflect the resident's discharge planning. On 1/15/2026 at 9:35 a.m. an interview with the Social Service Director revealed she was knowledgeable of Resident #8 and that he initially was admitted for short term therapy on 9/26/2026. She further revealed he had some payor source changes since his admission and his ultimate goal it to finish rehabilitation services and discharge to a nearby Assisted Living Facility. The Social Service Director confirmed there should have been a care plan to reflect his discharge planning and with interventions and her department (Social Services), is the department that usually develops that. The Social Service Director revealed the Care Plan to reflect discharge planning must have been overlooked. On 1/15/2026 at 4:00 p.m. the Nursing Home Administrator (NHA) provided the Plans of Care) policy and procedure with a last revision date of 9/26/2025 for review. The policy revealed;Policy - An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements.Plans of care is to be maintained as part of the final medical record. Procedure:Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.Develops and implements an Individualized Person-Centered baseline plan of care within 48 hours of admission that includes, but not limited to, initial goals based on the admission orders, therapy services, social services, PASARR recommendations, if applicable, and other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's needs are met appropriately until the comprehensive plan of care is completed. Develop and implement an Individualized Person-Centered comprehensive plan of care by the Interdisciplinary Team that includes but not limited to - the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of the food and nutrition services staff, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident, and, to the extent practicable, the participation of the resident and resident's representative(s) within seven (7) days after completion of the comprehensive assessment (MDS).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure Activities of Daily Living (ADL) care was provided for three residents (#12, 16, 57) of four residents sampled. Findings include: On 1/12/2026 at 9:28 a.m., Resident #12 was interviewed and observed with long, soiled fingernails and said, they don't help you here, when asked about the condition of his nails. On 1/15/2026 at 9:24 a.m., Resident #12 was observed with fingernails still long and soiled. Review of Resident #12's tasks report for 12/17/2025 to 1/15/2026 revealed the residents shower schedule is Saturday, Monday, and Thursday. The resident had a shower or bath for six days (12/17/2025, 12/19/2025, 12/24/2025, 1/5/2025, 1/6/2025) in the 30-day period of 12/17/2025 to 1/15/2026. Many of the days on the task sheet were checked as Not Applicable. Review of admission Records showed Resident #12 was admitted to the facility on [DATE] with diagnoses including but are not limited to cerebrovascular disease, heart failure, abnormalities of gait and mobility, need for assistance with personal care, and cognitive communication deficit. Review of Resident #12's Minimum Data Set (MDS), dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of four. This BIMS score indicated they have severe cognitive impairment. Functional Abilities revealed a code four for personal hygiene, which means the resident needs supervision or touching assistance. Shower/bathe revealed the resident would need substantial or maximal assistance. Review of Resident #12's Care Plan dated 12/16/2025 revealed a focus of alteration in usual functional performance in mobility or transfer status. This is related to muscle weakness and impaired mobility. Interventions showed functional status may vary on a day-to-day basis, staff are to provide support as needed. The resident requires partial to moderate assistance with one staff assist for tub/shower transfers. Supervision or touching assistance with one staff assist is required for personal hygiene. On 1/12/2026 at 10:02 a.m., an interview and observation occurred of Resident #16. Resident #16 stated not happy with their care at the facility. Resident #16 stated the staff have never assisted with or cared for her fingernails and toenails. Resident #16 stated their nails were long and they did not want them that way. Observed the fingernails to extend beyond the fingertip, with visible jagged edges and with a soiled appearance. An interview with Resident #16 was conducted on 1/15/2026 at 1:24 p.m. Resident #16 stated not receiving showers on scheduled shower days, including on 1/13/2026. Review of admission Records showed Resident #16 was admitted to the facility on [DATE] with diagnoses including but are not limited to acute on chronic diastolic heart failure, generalized muscle weakness, chronic respiratory failure with hypercapnia, need for assistance with personal care, and other abnormalities of gait and mobility. Review of Resident #16's MDS, dated [DATE], showed a BIMS score of 14. This BIMS score indicated they are cognitively intact. Functional Abilities revealed level 2 for self-care, which means the resident needs partial assistance from another person to complete any activities. Shower/bathe showed the resident would need the helper to support all of the effort. The assistance of two or more helpers is required to complete the activity. Review of Resident #16's Care Plan revealed a focus of alteration in usual functional performance in self-care related to muscle weakness and impaired weakness, respiratory failure. The intervention listed personal hygiene as supervision or touch assist with one staff assist. Shower and bathing are listed as dependent with one staff assist. Tub and shower transfers require partial/moderate assistance with one staff assistance. An interview was conducted with Resident #57's family member on 1/12/2026 at 11:14 a.m. The family member stated the facility staff do not shower the resident as scheduled therefore they come into complete the task. The family member stated the family cuts the resident's fingernails, as the facility had failed to assist. Review of the resident task report revealed the residents shower schedule is Monday, Wednesday, and Friday. No shower was recorded on 1/12/2026. Review of admission Records showed Resident #57 was admitted to the facility on [DATE] with diagnoses including but are not limited to Parkingson's Disease without dyskinesia, Unspecified dementia, major depressive disorder, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	encephalopathy, and blindness in the left eye (category 5). Review of Resident #57's MDS, dated [DATE], BIMS score of 0. This BIMS score indicated they have severe cognitive impairment. Functional Abilities revealed a level 1 for personal hygiene, which is substantial or maximal assistance. Review of Resident #57's Care Plan revealed a focus of alteration in usual functional performance in mobility/transfer status related to muscle weakness and impaired mobility due to resident's diagnoses. The residents' intervention include tub/shower transfers are dependent with two staff assist. The resident's personal hygiene is dependent on one staff assist. Shower/bathing is dependent on one staff assist. An interview was conducted with Staff P, Certified Nursing Assistant (CNA) on 1/14/2026 at 11:00 a.m. Staff P, CNA stated the CNAs perform shaving, nail care, showers, mouthcare, and other basic ADL care. She said she will introduce herself to the resident and tell them today is shower day. She lets them know if they refuse their shower, then she may not be able to get back to them. She will document the care in the electronic medical record. She stated there are not individual sections for nail care on the CNA shower sheets. Staff P stated the Activities Department will occasionally manicure resident's nails. An interview was conducted with Staff H, Registered Nurse (RN) and Unit Manager (UM) on 1/15/2026 at 9:10 a.m. Staff H, RN/UM stated that on the shower sheet, the CNA would write if the resident needs fingernails cut in the area on the sheet that asks about toenails. If they mark yes on the toenails, the podiatrist would be scheduled. Staff H stated the Social Services Director has the podiatry list. If the resident is not diabetic or has any other risk factors, then the nurses can cut the toenails. Staff H could not find a shower sheet for Resident #16 for Tuesday 1/13/26. Staff H was able to find the shower sheet for Resident #16 around 30 minutes later. Resident #16's shower sheet, dated 1/13/2026 was checked as the resident needing toenails cut, but not fingernail information. Resident #57's shower sheet, dated 1/12/2026 revealed the resident need their toenails cut. Resident #12's shower sheet had no notes describing fingernails or check marks in the toenail area on 1/13/2026. Review of the facility podiatry list revealed that Resident # 16 and Resident #57 were not on the podiatry list for needing care. An interview was conducted with the Resident Council President on 1/15/2026 at 1:15 p.m. They stated that one of the CNAs told the residents they do not cut nails. The resident stated the CNAs told them they will file them and straighten them but not cut them. They stated Podiatry comes in to take care of our feet, but it depends on the person and their feet. Review of the facility policy titled Care of Nails, with a revision date of 9/1/2017 revealed the facility procedure does include trimming fingernails and cleaning the nails. Review of the facility policy titled Bathing/Showering, with a revision date of 9/1/2027, revealed assistance with showering and bathing will be provided at least twice a week and PRN to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and PRN cleansing. Their preference for bathing will be reviewed at least quarterly during the care conference.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interview and record review the facility failed to ensure a resident's hearing aid was consistently available and utilized as needed to maintain communication, dignity, and quality of life for one (#72) of one resident reviewed.Findings include:On 1/12/26 at 9:51 a.m. during an observation and interview of Resident #72, a friend of the resident reported the facility staff failed to properly manage the resident's hearing aids, resulting in the devices being lost. The visitor stated facility staff did not remove the hearing aids at night. As a result, the resident has been without hearing aids for a while.A review of Resident # 72's admission record revealed admission to the facility on 1/29/25.A review of Resident #72's Admit/Readmit Screener dated 1/29/25 revealed right and left ear hearing aids present.A review of Resident # 72's health status note, dated 2/4/25 revealed .I placed her hearing aids in before breakfast .A review of Resident # 72's health status note, dated 2/14/25 revealed .her left hearing aid is in this am and staff cannot find the right hearing aid .A review of Resident # 72's health status note, dated 2/17/25 revealed .I placed both hearing aids in the [morning before] breakfast .A review of a grievance regarding Resident #72, dated 8/29/25 revealed the following:Concern: Family expresses that resident is missing her hearing aids.-Findings of investigation: After a search was done, hearing aids could not be located.-Plan to resolve complaint/grievance: Explained to family that hearing aids were not added to inventory sheet when brought in.-Expected results of actions taken: Also not order for hearing aids in system. Explained that resident can be enrolled to see audiologist in order to get new hearing aids .-Post investigation follow-up: Family satisfied with outcome . dated 8/29/25.A review of an email from the facility to their audiology services vendor dated, 10/21/25 revealed could you please add [Resident #72] to this upcoming visit .She had lost her hearing aids and has been needing a new pair for a while now .During a telephone interview on 1/14/2026 at 11:03 a.m. with Resident #72's representative said in August, the facility acknowledged the loss of the resident's hearing aids but stated they would not replace them. The facility told her if the resident enrolls in audiology services and obtained a new pair of hearing aids, the facility will assume responsibility for replacement should the devices be lost in the future.During an interview on 1/14/26 at 4:24 p.m. with the Nursing Home Administrator (NHA), the Director of Nursing (DON) and the Regional [NAME] President of Operations (RVPO). The RVPO said Resident #72's family was initially concerned about the resident's cognitive ability to keep up with her hearing aids. A review of the facility policy and procedure titled, personal property- loss or theft, revised on 7/24/2017 revealed the following-Policy: The Center has processes to minimize the risk of loss or theft of resident's personal property revealed- Process: 1. At admission resident's belongings will be identified and recorded.A review of the facility policy and procedure titled, care of hearing aid, revised 9/1/17 revealed the following- Procedure: . Place hearing aid in appropriate container when not in use and store in safe place .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to follow the clinical standard of practice to ensure adequate monitoring of behaviors and medication side effects for a resident prescribed psychotropic medication. This failure affected one (#41) of five residents reviewed.Findings included: A review of admission record revealed Resident #41's was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis' including but not limited to dementia, major depressive and mood disorder. A review of resident #41's care plans revealed: Focus: [Resident #41] uses antidepressant medication, initiated on 10/07/2025 Goal: The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Interventions: Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness every shift . A Review of Resident #41's psychiatry care plan note, dated 11/5/25 revealed In addition to monitoring for the occurrence of potential adverse effects from medications, we are also monitoring the following: any drug-drug, drug-disease interactions, the impact of any adverse effects on the patient's ability to perform activities of daily living or to interact with others; withdrawal from or decline in usual social patterns; decreased engagement in activities; and diminished ability to think or concentrate . A review of Resident #41's psychiatry subsequent note dated 1/7/26 revealed .mood swings are severe requiring monitoring .monitoring for the occurrence of potential adverse effects from medications . A review of order summary report dated 1/15/26 revealed Resident #41 had orders for the following medications. Depakote 500 mg give 1 tablet orally two times a day for mood disorder-1/8/26, Depakote 500 mg give 1 tablet orally give 2 tablets orally at bedtime for mood disorder-12/24/25, Donepezil HCl 10 mg give 1 tablet orally at bedtime related to unspecified dementia, unspecified severity, with other behavioral disturbance-7/8/25, Lorazepam 0.25 ml injection every 4 hours as needed for anxiety/restlessness-1/14/26, Paroxetine 10 mg orally give 1/2 tablet daily for major depressive disorder-1/9/26, and Zunveyl 10 mg orally two times daily-1/14/25. Discontinued medications Paxil 10 mg orally daily for depression-7/3/25 and Seroquel 25 mg 1/2 tablet orally twice daily for depression-7/2/25. During an interview on 1/25/26 at 8:45 a.m. Staff V, Registered Nurse (RN), said behavior monitoring is documented in the Medication Administration Record (MAR). If a resident is exhibiting behaviors, staff document the behavior, notify the provider, administer PRN medications as ordered, and may request an order for psychiatric consult. During an interview and record review on 1/15/26 at 8:59 a.m. with Staff H, RN, Unit Manager (UM) said the facility have standing orders to monitor residents who are prescribed psychotropic medications. She said behavior monitoring is documented on a behavior flow sheet in the electronic health record (EHR). Staff H, RN/UM was unable to show Resident #41's behavior monitoring documentation. She referred to asking the Director of Nursing (DON) to print the behavior monitoring documentation. During an interview on 1/15/26 at 9:10 a.m. the Director of Nursing (DON) said behavior monitoring is documented on the Medication Administration record (MAR). He opened Resident #41's EHR and revealed an order dated 1/14/26 for behavior monitoring. When asked to provide documentation of behavior monitoring for November 2025, December 2025 and January 2026, he stated that it is documented in the resident's progress notes. He was asked to provide documentation of behavior monitoring for the past three months, as recommended by psychiatry. During a follow-up interview on 1/15/26 at 12:20 p.m., the DON said no documentation of behavior monitoring was found for Resident #41 and acknowledged that behaviors were not documented daily. During a telephone interview on 1/15/26 at 1:30 p.m. Resident #41's Psychiatric Mental Health Nurse Practitioner (PMHNP) said he expects Resident #41's behaviors are monitored every shift; the resident is very confused.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record reviews, and interviews the facility failed to ensure a medication error rate of less than 5.00%. Twenty-six medication administration opportunities were observed, and ten errors identified for two (#93 and #1) of five residents observed. These errors constituted a 38.46% medication error rate.Findings include:On 1/13/25 at 8:24 a.m. an observation of medication administration with Staff M, Respiratory Therapist (RT) was conducted with Resident #1. Staff M, RT picked up a nebulizer mask stored uncovered on top of the bedside table, poured the prescribed amount of Budesonide inhalation solution into the nebulizer cup. She connected the nebulizer cup to the nebulizer mask and turned on the nebulizer machine [A nebulizer is an electric machine that turns liquid medication into a fine mist that is inhaled into the patient's lungs by a facemask]. Staff M, RT handed the mask to Resident#1 and the resident positioned the mask and immediately began to inhale the medication. Staff M, RT used a stethoscope to listen to the Resident #1's lungs. Review of Resident #1 medication orders revealed the following orders:-Budesonide (Inhalation) 0.5 milligram (mg)/2 milliliter (ml) inhale orally two times a day for Shortness of breath(SOB) Respiratory: Check lung sounds, heart rate and respirations Pre and Post-Nebulizer administration. Record Minutes of nebulizer treatment.- Ipratropium-Albuterol 1 vial inhale orally four times a day for Shortness of breath(SOB) Respiratory: Check lung sounds, heart rate and respirations Pre and Post-Nebulizer administration. Record Minutes of nebulizer treatment.During an interview immediately after the medication was administered, Staff M, RT shrugged her shoulders when asked why the physician's orders to check Resident #1's lungs before beginning Budesonide inhalation solution administration was not followed. On 1/13/25 at 10:21 a.m. an observation of medication administration with Staff K, Licensed Practical Nurse (LPN) was conducted with Resident # 93.A review of Resident #93's order summary report dated 1/15/26, showed orders for the following medications:-Rivaroxaban Tablet 15 milligrams (mg) tablet orally-Amiodarone HCl Tablet 200 mg tablet orally-Polyethylene Glycol 3350 17 gram (gm) orally- Ascorbic Acid Tablet 500 mg tablet orally- Bimatoprost Ophthalmic Solution daily-Levothyroxine Sodium 75 microgram (mcg) oral tablet- Cyanocobalamin 1000 mcg intramuscularly-Isosorbide Dinitrate 5mg tablet orally- Donepezil Hydrochloride 10 mg tablet orally- Coenzyme Q10 30 mg capsule orally- Biotin 1000 mcg tablet orally- Sennosides Tablet 8.6 mg tablet orally- Docusate Sodium 1 capsule orally- Pantoprazole Sodium 40 mg tablet orally- Famotidine 20 mg tablet orally-Loratadine 10 mg tablet orally- Lactobacillus 1 capsule orallyStaff K, LPN administered the following oral medications:-Lactobacillus scheduled for 9:00a.m. was given at 10:21 a.m.-Docusate Sodium scheduled for 9:00a.m. was given at 10:21 a.m.-Coenzyme Q10 scheduled for 9:00a.m. was given at 10:21 a.m.-Ascorbic Acid scheduled for 9:00a.m. was given at 10:21 a.m.-Biotin scheduled for 9:00a.m. was given at 10:21 a.m.-Amiodarone scheduled for 9:00a.m. was given at 10:21 a.m.-Isosorbide Dinitrate scheduled for 9:00a.m. was given at 10:21 a.m.-Sennosides scheduled for 9:00a.m. was given at 10:21 a.m.Polyethylene Glycol scheduled for 9:00a.m. was given at 10:21 a.m.During an interview immediately after the medications were administered Staff K, LPN said Resident #93's medications were given late because she had to complete discharge paperwork for another resident.A review of a facility policy titled, administering medications, revised April 2019 revealed the following:Policy Statement-Medications are administered in a safe and timely manner, and as prescribed.Policy Interpretation: .2. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions . 3. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions . 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).A review of a facility policy titled, nebulizer (small volume nebulizer), revised on 3/20/2018 revealed the following: Note-Small volume nebulizers are used to deliver medication aerosols to the respiratory tract to relieve bronchospasm, to deliver medications, to improve the effectiveness of the cough and to relieve mucosa edema. Small volume nebulizers create (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a mist from a liquid medication solution that can be inhaled into the bronchial tree. Droplets of mist are delivered through a facemask or mouth piece and absorbed into the bloodstream through alveoli within lung tissue.Procedure:Review physician's orderGather necessary equipment.Identify resident and explain the treatment.Perform hand hygiene.Position the resident in an upright position.Evaluate the resident. Establish baseline respiratory rate, pulse, oxygen saturation and breathe sounds.-Assemble nebulizer equipment.-Instill the prescribed medication into nebulization cup.-If using handheld nebulizer, instruct the resident to hold the mouth piece between the lips. If using mask for delivery, --place the mask on the resident.-Instruct the resident to take slow deep breathes and exhale slowly.-Administer treatment until medication is depleted-Evaluate the resident's response and effectiveness of treatment by evaluating breath sounds, pulse rate, oxygen saturation and respiratory rate.-Disassemble device and rinse the mouthpiece and nebulizer cup with water and air Place entire unit in a bag to be maintained in the resident's room.-Perform hand hygiene-Document treatment in the resident's medical record.

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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. Based on observations, interviews and record review, the facility did not ensure medications were not accessible to unauthorized staff, residents, and visitors for one resident (#64) of 53 sampled residents.Findings include:On 01/12/2026 at 9:30 a.m. an observation was made of Resident #64 sitting on his bed. A breakfast tray was observed at bedside. On the meal tray was a plastic medication cup with what Resident #64 referred to as morning medications. The resident stated the nurse left the medications there a while ago. Resident #64 confirmed those were his morning medications mixed in pudding. Resident #64 stated, The meds are lumpy. I cannot swallow them. Resident #64 stated having trouble swallowing solids and was on a liquefied diet.An interview was conducted on 01/12/2026 at 10:32 a.m. with Staff S, Registered Nurse (RN). Staff S confirmed leaving the medications unattended at resident #64's bedside table. Staff S walked into the room and observed the plastic cup full of medications still at bedside. She stated she had crushed the medications and left them in the room for the resident. She stated the resident has trouble swallowing solids. She said everything had to be in liquid for this resident and that he normally took his time when taking them. Staff S stated she told Resident #64 to, let the medications melt first, and she would be right back. Staff S stated she should have supervised the resident during medication administration.On 01/14/2026 at 1:08 p.m. an interview was conducted with Staff H Registered Nurse (RN) Unit Manager. The unit manager stated for a medication pass to be considered proper, the nurse should verify the correct route ordered. Staff H said, At no time should a resident be left alone with medications. The nurse gives the patient the pills then they stay in the room and verifies that the medication is given correctly and taken. Staff H confirmed the nurse must watch the medication administration. She said, They are to stay while the meds are taken.An interview was conducted on 01/14/2026 at 10:07 a.m. with the Director of Nursing (DON) stated that no medications should be left unattended at a resident's bedside.Review of a facility policy titled, Administering Medications, revised April 2019, showed a policy statement - Medications are administered in a safe and timely manner, as prescribed. 4. Medications are administered in accordance with prescriber orders, including timeframes. 27. Residents may self-administer their own medications only if the Attending physician, in conjunction with the Interdisciplinary care Planning Team, has determined that they have the decision-making capacity to do so safely.Review of an undated facility policy titled, Medication Storage, revealed a policy - Medications will be stored in a manner that maintains integrity of the product and ensures the safety of the residents and is in accordance with FL (Florida) Department of health guidelines. Procedure A. all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined by facility policy.

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	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Bradenton	105 15th St E Bradenton, FL 34208

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to honor one (#64) of eight sampled residents with meals that were in the form of the resident's choice and dietary recommendation.Findings include: On 1/12/2026 at 9:31 a.m. Resident #64 breakfast tray was observed to have four bowls. One bowl was observed to have a yellow solid pulpy mass, the second bowl containing brown food item in the form of a scooped unidentifiable food substance, the third bowl contained white disk shaped unidentifiable solid food substance, and the fourth bowl appeared to be an applesauce texture substance. The meal ticket was observed beside the food tray which read all foods in bowls, all foods liquified. The statement on the meal ticket was highlighted in yellow. On 1/13/2026 at 9:00 a.m. Resident #64 breakfast tray was observed to have two uncovered bowls and one covered bowl. The uncovered bowl contained a yellow solid pulpy mass, and the other bowl appeared to be an applesauce texture substance. The meal ticket revealed, all foods in bowls, all foods liquified and that statement on the meal ticket was highlighted in yellow. During an interview on 1/13/2026 at 9:55 a.m., Resident #64 said, If the eggs were spread out with liquid, I could eat them but not in this lump. During an interview on 1/14/2026 at 7:35 a.m. with Staff B, Dietary Aide, who was handling the meal tickets and reviewing them, said he will review the meal tickets for diet type, diet consistency, allergies, likes/dislikes and any other special dietary orders. Staff B said the highlighting was to ensure they [the kitchen staff] follow the special instructions and will verbally call it out to the cook. Staff B said the tickets, and plated food is reviewed by at least three staff on the tray line to include himself, the cook, and the aide that takes the plated food/tray and places it in the tray cart. During an interview on 1/14/2026 at 7:45 a.m. the Regional Dietary Manager stated at least three staff members in the kitchen verify the meal tickets and ensured the orders/choices are followed/honored prior to going out to the residents. During an observation and interview on 1/14/2026 at 7:46 a.m. Staff B, Dietary Aide (DA) placed Resident #64's meal ticket on a plastic meal tray and sent the tray down the line. The meal ticket was then reviewed by the Staff A, [NAME] and he plated the resident's food items to include a bowl of scrambled (puree) eggs, a bowl of dark brown food (item biscuits for biscuits and gravy), Staff A then placed clear plastic wrap on both of the bowls and gave the entire meal tray to the last aide on the tray line. Observations revealed the bowl of puree eggs, and the bowl of puree sausage biscuit had not been liquified, per the meal ticket order. The bowls were shown to Staff A and he looked at the bowls and said, Oh I must have just missed that. Staff A explained that the eggs and the sausage and biscuit needed to be liquid with water and mixed/emulsified. During an interview on 1/14/2026 at 8:00 a.m. with the Regional Dietary Manager (RDM) confirmed the meal ticket for Resident #64 was not followed and stated Resident #64 was the only resident that had this specialized diet. The RDM reviewed the ticket and confirmed the texture was not correct. Durning an interview on 01/14/2026 at 11:45 a.m. with Staff T, Speech Language Pathologist (SLP) stated Resident #64 has trouble swallowing and the assessment and recommendations made were to liquidize Resident #64's food. Staff T said Resident #64 complains he has not been able to chew the food without adding liquid. Staff T, SLP was shown the photo of the meals from 1/12, 1/13, and 1/14, that Resident #64 had received and confirmed no liquid was added to the food. During an interview on 01/14/2026 at 2:53 p.m. Staff C, DA was shown photos of the meals Resident #64 received and Staff C confirmed that no liquid was added as it should have been as it was on the meal ticket. Staff C said the staff was expected to review resident choice and diet order on the meal ticket and highlight it on the meal ticket to make it easy for the cook to prepare the meal. Staff C explained that once it's on the food ticket It's expected we follow through with what is on the food ticket. Review of Resident #64's quarterly assessment Minimum Data Set (MDS) dated [DATE] showed an admission date of 11/20/2024 with diagnoses to include type two diabetes mellitus with (continued on next page)

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	105551	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Bradenton	105 15th St E Bradenton, FL 34208

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unspecified diabetic retinopathy without macular edema, iron deficiency anemias, muscle weakness, dysphagia oropharyngeal, protein-calorie malnutrition, and other diagnoses. Review of the Order Summary Report dated as active orders as of 01/15/2026 the diet order read Dysphagia puree texture, regular/thin consistency, all food in bowls and liquified per resident request. Review of Resident #64's Progress notes entered and signed on 11/21/2025 at 9:24 a.m. by Staff T, SLP revealed diet to regular liquids continue puree/liquidized solids. Review of the facility's policy and procedure titled, Dining and Food Preferences, dated October 2022, revealed that individual dining, food, and beverage preferences are identified for all residents/patients. Procedure number four listed in the policy statement indicated that food and fluid preferences will be entered into the resident profile in the menu management software system. Procedure number seven states the individual tray assembly ticket will identify all food items appropriate for the resident/patient based on diet order. and preferences.

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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 - Few	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 interview and record review the facility failed to ensure documentation was complete and accurate for one (#57) of one resident reviewed timely medication administration documentation. Findings include: An interview was conducted with Resident #57's family member on 1/12/2026 at 11:14 a.m. The family member stated they are concerned that the facility staff are not giving medication to Resident #57 timely. The family member stated Resident #57 reports to her the facility only gave the medications twice in one day although ordered for three times per day, but the nurse said it had been administered three. Review of the admission Records showed Resident #57 was admitted to the facility on [DATE] with diagnoses including but are not limited to Parkingson's Disease without dyskinesia, Unspecified dementia, major depressive disorder, encephalopathy, and blindness in the left eye (category 5). Review of Resident #57's Minimum Data Set (MDS), dated [DATE], showed Brief Interview for Mental Status (BIMS) score of 0. This BIMS score indicated they have severe cognitive impairment. Review of Resident #57's Care Plan, dated 12/15/2025, revealed a focus of Parkinson's disease, with a risk for neurological problems. An intervention listed states to give medications as ordered by the physician, then to monitor/document the side effects and effectiveness. Review of the Medication Audit report revealed Entacapone oral Tablet 200 mg, scheduled for 0900, 1300, and 1700 were administered at the same time in the Medication Administration Report (MAR) records in the afternoons on the following dates: 1/10/2025, 1/5/2026, 12/31/2025, 12/22/2025, 12/17/2025, 12/2/2025 Review of the Medication Audit report revealed Carbidopa-Levodopa Oral Tablet 25-100 mg with admissions scheduled for 0900, 1300, and 1700 were administered at the same time in the MAR records in the afternoons on the following dates: 1/10/2025, 1/5/2026, 12/31/2025, 12/22/2025, 12/17/2025, 12/2/2025 An interview was conducted with Staff L, Licensed Practical Nurse (LPN) on 1/14/2026 at 10:17 a.m. Staff L, LPN stated that she administers the medications at the right time, but she doesn't get a chance to chart until later. She said that the facility may have a policy, but sometimes it is impossible to chart the medications on time. She does not feel like they are short staffed. Staff L stated, things come up. Staff L confirmed not updating the progress notes on the days the medications are charted late. Staff L stated the electronic medication administration system does have an option to click see progress notes. An interview was conducted with the Director of Nursing (DON) on 1/15/2026 at 10:51 a.m. The DON stated just because the audit showed the medication was entered into the system at one time, that does not mean the medication was given at those times. He stated he would investigate the family's allegation of missed medications. The DON said there is no way to determine time medications are given if not documented at the time of administration. An interview was conducted with the DON on 1/15/2026 at 12:20 p.m. The DON stated the staff cannot combine documentation for medications. He said there is no policy on the documentation of medication administration. The DON said the expectation is medications are documented when given, to ensure accurately recorded. At no time should the nurse administer medication and record administration several hours later. If medication must be administered after the time allotted for administration, the medical doctor must be notified with the reason for the late administration. The nurse must also notify the family. Review of the facility policy titled Administering Medications, with an effective date of April 2019, revealed the policy statement of Medications are administered in a safe and timely manner, and as prescribed. Section 7 showed medications are administered within one hour of their prescribed time, unless otherwise specified.