

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 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 and interviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety and sanitary conditions, and to prevent foodborne illnesses, during 2 of 2 tours in the central kitchen. The findings included: A review of the Food Safety Guide dated September 19, 2023, showed that raw chicken should be in the refrigerator for 1 to 2 days https://www.foodsafety.gov/food-safety-charts/cold-food-storage-charts. In a tour of the central kitchen conducted on 09/08/2025 at 9:08 AM, accompanied by the food service manager, the following issues were noted: The reach in freezer was noted with a pack of frozen meat patties that were not labeled and did not have the date of when the frozen meat patties were placed in the freezer, nor did they have an expiration date. The reach in freezer was noted with a bag of frozen turkey patties that was labeled but did not have the date of when the turkey patties were placed in the freezer, nor did it have an expiration date. The reach-in freezer was noted with three large pieces of raw chicken that were labeled but did not have the date of when the chicken pieces were placed in the freezer and did not have an expiration date. The reach-in freezer was noted with a bag of unidentified frozen raw meat that was not labeled and did not have an expiration date and the date that the frozen meat was placed in the reach-in freezer. The reach-in freezer was noted to contain a bag of 6 large pieces of raw chicken that was open and unlabeled. The bag did not have the date that the chicken pieces were placed in the freezer and did not have an expiration date. The reach-in freezer was noted with a large bag of unidentified frozen meat that was not labeled and did not have an expiration date or the date that the frozen meat was placed in the reach-in freezer. The reach in freezer was noted with a bag of frozen raw pork that was labeled but did not have the date when the pork meat was placed in the freezer and did not have an expiration date. The walk-in refrigerator was noted with a large box of raw chicken that was not labeled or dated. When asked when it was placed in the walk-in refrigerator, the kitchen manager said that he had put the chicken last Thursday, on 09/04/2025. He further said that it was used for Sunday's meal and that it was going to be used for tonight's meal. The walk-in refrigerator was noted with 10 pounds of pork loin, but it did not have an expiration date or the date that the raw meat was placed in the walk-in refrigerator. A Hydriion meter was used to check the sanitation solution in one red bucket, which showed that it was between 400 and 500 parts per million. This showed too much sanitation solution, with normal ranges between 150 and 175-degrees Fahrenheit (F), and not the necessary 180 degrees or above. In an interview conducted on 09/08/2025 at 2:00 PM with the Kitchen Manager, he stated that he was told that the dishwasher needs to run a few times to reach 180 degrees and above before using it for dishes. In an observation conducted on 09/10/25 at 11:45 AM, Staff P, Cook, was noted in the food production area with no facial hairnet. He placed a facial hairnet during this observation, which covered his beard but not his mustache. In a second tour of the kitchen conducted on 09/11/2025 at 11:35 AM during the lunch tray line, the following were noted: A chocolate cream pie noted with an internal temperature of 50 degrees Fahrenheit (F) and another chocolate cream pie noted with an internal temperature of 50 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 105578
		If continuation sheet Page 1 of 22

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	degrees F. The remaining chocolate cream pies were placed on the individual's lunch trays. This was not at the appropriate temperatures of 40 degrees F and below. A steam table quarter-size pan of chopped pork loin was noted with an internal temperature of 125 degrees F, and not the necessary 155 degrees F and above for hot food. In this observation, the Kitchen Manager reheated the chopped pork loin and rechecked the internal temperature, which showed 158 degrees F and not the necessary internal temperature of 165 degrees F when reheating cooked pork loin that was cooked and cooled. The temperature of a cooked breaded chicken sandwich was taken using a facility-calibrated thermometer, showing an internal temperature of 85 degrees F. In this observation, the Kitchen Manager reheated the breaded chicken and checked the internal temperature. Further observation showed that the breaded chicken had an internal temperature of 115 degrees F after reheating, and not the necessary 165 degrees F or above. A pureed chocolate pudding was noted at 53 degrees F, and not the necessary 40 degrees F or below. In an interview conducted on September 11, 2025, at 3:00 PM with the facility's Administrator, he was informed of the findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and records review, the facility failed to ensure call lights were within reach for 3 of 25 sample residents (Resident #1, Resident #17 and Resident #22).The findings included:1. On 09/08/2025 at 10:48 AM, it was observed that a call light in the resident's room was attached to the back of Resident #22's bed's headboard. The observation prompted an interview with Resident #22 who reported through gestural confirmation, because of his tracheostomy, that he wanted to use the call light, but he could not reach it. Resident #22 affirmatively nodded, it was not the first time this situation occurred, when asked if that was the first time it had happened. To ensure that Resident #22 could use his hands, the Assistant Nurse Manager was immediately called to the room and was asked to hand the call light to Resident #22 and to have him press on it to activate it. Resident #22 successfully activated the call light.Resident #22 was admitted to the facility on [DATE] and was diagnosed with: Anoxic Brain Damage, Not Elsewhere Classified; Quadriplegia; Tracheostomy Status.Section GG of the MDS dated [DATE] documented Resident #22 had no impairment in range of motion for both upper and lower extremities. Section C was not assessed. Review of the Care Plan documented Resident #22 was at risk for falls. As preventive measures the CP outlined that staff would minimize risk of minor injury through the next review date. Also, the facility will make sure the resident's call light is within reach and will encourage the resident to use it for assistance as needed. At about 3:45 PM, on 9/10/2025, Staff N (registered nurse) was asked to come to the room to verify the position of the call light. Staff N acknowledged that the call light should not have been hanging by the bedside. She said the call light was not where it was supposed to be. Staff N also added that Resident #22 was totally dependent. Staff N said that Resident #22 could only use his call light, when it is reachable. Resident #22 could not roll from side to side. Therefore Resident #22's needs had to be anticipated. Staff N also said, they checked on Resident #22 every two hours. Staff N alleged that she saw Resident #22 about 20 minutes prior to the interview with her. Staff concluded when the call light is not within reach Resident #22 asked for it.2. On 09/09/2025 at 9:42 AM, an observation conducted in the resident's room revealed Resident #17's call light was on the floor. The call light was not within reach. The Resident said occasionally, when she requested her call light, they did not give it to her. During the interview, it was noted that Resident #17 could not see anything at all.During a follow-up visit to the Resident's room on 09/10/2025 at 3:45 PM, Resident #17's call light was again found on the floor. The resident was in bed sleeping.Resident #17 was admitted to the facility on [DATE]. Resident #17's diagnoses included Atherosclerosis; Mild Cognitive Impairment of uncertain or unknown etiology; Schizophrenia, Unspecified; Legal Blindness; Muscle Weakness (Generalized). The minimum data set (MDS) dated [DATE], section C revealed a score of 12/15 on the Brief Interview for Mental Status (BIMS). Section GG0115 of the MDS titled Functional Limitation in Range of Motion documented Resident #17 had No upper extremities impairments. The Care Plan (CP) dated 8/6/2025 documented Resident #17 was at risk for falls related to confusion, Gait/balance problems, periods of Incontinence, Psychoactive/ antidepressant drug use, Vision problems. The goals were to minimize the risk of falls through next review date; Minimize risk of minor injury through the next review date. As intervention staff would make sure Resident #17's call light was within reach and she would be encouraged to use it for assistance, as needed. 3. On 09/08/2025 at 11:01 AM, in the resident's room, Resident #1's call light was observed in a nightstand drawer. Resident #1 could not reach the call light due to physical limitations and contractures in both hands. Resident #1 said that the call light did not work the day before, Resident #1 said he had been trying to get someone to come to his room to lower the head of his bed, but he did not see, nor could he reach the call light. The bed control was also observed on the floor away from Resident #1. On 09/09/2025 at 11:24 AM, Resident #1's call light was observed attached to his bed and was also replaced by a softer touch call light instead of the push-button call light Resident #1 previously had.Review of the MDS revealed a significant change (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was processed on 8/4/2025. Section C of the MDS revealed Resident #1 obtained a score of 12/15 on the BIMS. In section GG0130 titled self-care documented Resident #1 had bilateral hands impairment. The CP dated 3/11/25 outlined Resident #1 was at risk for falls related to: Gait/balance problems and Incontinence. The goal was to minimize risk of minor injury through the next review date. To do so, Staff would make sure the resident's call light was placed within reach and Resident #1 would be encouraged to use it for assistance, as needed. The findings were reported to the Director of Nursing, the Corporate Nurse, and the Administrator during the initial observation and at the end of the survey on 9/13/2025.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 observations, interviews and record reviews, the facility failed to follow their own policy regarding grooming for Activities of Daily Living (ADL) for 1 of 21 sampled residents (Resident #40). The findings included: A review of the facility's policy titled, Grooming Activities, revised on 03/19/19, documented the following: o Grooming activities are provided to assist residents in meeting their physical needs as well as self-esteem needs. o Grooming activities shall be offered daily. o Grooming activities shall include, but not limited to: Shaving Combing hair Nail care A record review documented Resident # 40 was admitted to the facility on [DATE] with diagnoses that included Displaced Intertrochanteric Fracture of the Left Femur, and Muscle Weakness. An electronic record review of the annual Minimum Data Set (MDS) assessment, under Section C of the Brief Interview for Mental Status (BIMS), revealed a score of 13 indicating Resident #40 had no cognitive impairment. A review of the nursing care plan dated 09/06/24 revealed a focus noting Resident #40 had an ADL self-care performance deficit related to impaired balance, left hip/pelvis fracture and weakness. The nursing care plan interventions included bathing /showering: provide sponge bath when a full bath or shower cannot be tolerated; skin inspection: the resident requires skin inspection. In an interview conducted with Staff D, Certified Nursing Assistant (CNA), on 09/08/25 at 11:09 AM, who stated she has been working in the facility for 3 years. She stated she usually brings the shaving supplies inside the residents' rooms. She also brings whatever they need. She takes the supplies from the central storage rooms. She added that she uses a different blade for each resident, she puts them in plastic trash after usage. When she was asked if she offered to shave a resident assigned to her, she responded, No resident asked her for a shave. During an observation conducted on 09/08/25 at 2:14 PM, Resident #40 stated he requested facial shaving from a staff, but staff did not respond, did not provide him with shaving supplies or offered to shave him. An observation of the assignment board dated 09/08/25 revealed Staff E, Certified Nursing Assistant (CNA) was assigned to Resident #40. In another interview conducted with Resident #40 on 09/09/25 at 9:17 AM, he stated he is still waiting for a shave. He added that he asked the staff again, but staff did not respond or offered to shave him. When he was asked about the name of the staff, he responded, he does not know because she would not tell him her name. A review of the assignment board for 09/09/25 revealed that Staff D, CNA, was assigned to Resident #40. During another observation conducted on 09/09/25 at 12:19 PM, Resident #40 still had long facial hair around his mouth and chin. He added that no staff offered to shave him. In an interview conducted with Staff C, CNA on 09/09/25 at 3:36 PM, who stated she has been working in the facility for 20 years. When she was asked how she would know a resident needs shaving, she responded, By looking at the resident's face, I will know if he needs shaving. She added that when a resident refused to shave, she would try and asked the resident again at a later time. Sometimes a resident would ask her to stop shaving halfway, so she would listen to the resident. She added that she provides the shaving supplies, and she would do the shaving too, if the resident is not able to shave by himself. In an interview conducted with Staff B, CNA on 09/09/2025 at 4:40 PM, who stated she has been working in the facility for 4 years. When she was asked if she ever offered to shave Resident #40, she responded, she never had a chance to ask him. She added that she asked this resident before, but he refused to shave. She would ask him again today. During an observation conducted on 09/09/25 at 4:50 PM, Resident #40's face still had approximately 2 inches long whitish hair around his mouth and below his chin. In an interview conducted with Staff E, CNA, on 09/10/2025 10:23 AM, when she was asked why she provided facial shave to this resident, she responded, I saw his facial hair was about 2 inches long and asked the resident if he would like a shave, and the resident, responded, yes. She added that the 3:00 PM to 11:00 PM shifts staff are the ones responsible for providing showers, but because she saw the resident with long facial hair, she decided to give him a shower. She added that this resident also asked for a shave today. When she (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was asked what other personal care was provided to Resident #40, she responded, I gave him a shower today. When she was asked what shower includes, she responded, The staff washes from top to bottom. The hair is shampooed; the nails are cleaned including both fingernails and toenails. When she was asked if she was the staff assigned to Resident #40 on Monday, 09/09/25, she responded that she does not remember. When she was asked if Resident #40 requested a shave on Monday, she responded that she does not remember.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to follow fall interventions and failed to complete a post-fall assessment for 1 of 5 sampled residents (Resident #23).The findings included:A record review revealed that Resident #23 was readmitted to the facility on [DATE] with diagnoses of Anemia and Muscle Weakness. The Quarterly Minimum Data Set, dated [DATE] revealed Resident #23 had a Brief Interview Mental Status (BIMS) score of 04, which indicated severe cognitive impairment. An order dated 09/02/2025 for bilateral floor mats for safety.A review of the facility's policy titled Fall Management dated 07/29/2019 showed the following: the purpose of this policy is to identify residents at risk for falls and to establish and modify interventions to decrease the risk of future falls and minimize the potential for a resulting injury. Initiate post-fall documentation every shift for 72 hours. In an observation conducted on 09/08/25 at 11:00 AM, Resident #23 was noted in the bed with a fall mat folded on the right side of the bed and a fully opened mat on the left side of the bed. Further observation did not show that the bed was in the lowest position. In an observation conducted on 09/08/25 at 3:15 PM, Resident #23 was not in the room. The two floor mats were folded on each side of the bed. Further observation did not show that the bed was in the lowest position.In an observation conducted on 09/11/2025 at 9:55 AM, Resident #23 was noted in the bed with a fall mat folded on the right side of the bed and a fully opened mat on the left side of the bed. The Care plan revealed the following: Resident #23 has had an actual fall on 02/08/2025, 03/29/2025, and on 07/22/2025, with the following interventions in place: bed in low position initiated on 02/11/2025, bilateral floor mats placed for safety initiated on 07/22/2025 and determine and address causative factors of the fall. Further record review showed that post-fall assessments were conducted on 07/28/2025, which was 6 days after the actual fall on 07/22/2025.In an interview conducted on 09/10/2025 at 12:53 PM with the facility's Director of Nursing, she reported that after a fall, they need to assess the residents and ensure no injuries. They need to notify the family and the doctor and update the care plans for interventions. She further said that they complete a post-fall assessment every shift for 72 hours. In an interview conducted on 09/10/25 at 2:47 PM with Staff A, a Certified Nursing Assistant, she stated that Resident #23 was a fall risk and there are interventions in place. The bed needs to be in the lowest position, fall mats on both sides of the bed, and ensure the call lights are within reach and close to the Resident.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to attain weekly weights and identify significant weight loss in a timely manner for 1 of 3 sampled residents (Resident #55). The findings included: A review of the facility's policy titled Weighing the Resident, revised on 10/04/2021, showed the following: When there is a significant variance from the previous recorded weight, the scale should be rebalanced and the resident reweighted, and a licensed nurse should validate. It further showed to record the weight and alert the nurse to any significant change. A chart review revealed Resident #55 was admitted to the facility on [DATE] with diagnoses of Anemia, Dementia, and Dysphagia. The annual Minimum Data Set (MDS) dated [DATE] showed Resident #55 with a Brief Interview of Mental Status (BIMS) score of 12, which is low to moderate cognitive impairment. In an observation conducted on 09/08/2025 at 12:13 PM in the main dining area, Resident #55 was eating her lunch meal. Further observation showed that she ate above 75% of her meal. A review of the weight history for Resident #55 showed the following: 07/07/2025, weighing 162 pounds. 08/05/2025 with a weight of 153 pounds. 08/11/2025, weighing 150 pounds. 08/11/2025, with a weight of 167 pounds, which was mismarked. 09/05/2025 with a weight of 145.8 pounds. The above shows that Resident #55 experienced a significant weight loss of 5.5% in one month. The above shows that Resident #55 experienced a significant weight loss of 10% in approximately 2 months. The nutrition care plan revealed that Resident #55 was at risk for malnutrition related to advanced age and medical conditions. The resident will maintain adequate nutritional status as evidenced by maintaining weight, with no signs and symptoms of malnutrition, and consuming at least 75% of her meals. Monitor/record/report any significant weight loss: >5% in 1 month, >7.5% in 3 months, and >10% in 6 months. A review of the Nutrition assessment dated [DATE] revealed Resident #55 had a significant weight loss-a current body weight of 153 pounds, with a usual body weight of 160 to 165 pounds. To begin weekly weights for monitoring, and to start Med Pass (nutritional supplement) once a day, providing an additional 240 calories and 10 grams of protein. A follow-up nutrition note dated 08/12/25 revealed Resident #55 was on a weekly weight regimen due to significant weight loss, and the current body weight was noted at 167 pounds. In this note, the facility's Dietitian pointed out that the weight of 153 pounds on 08/05/2025 was erroneous and to continue weekly weight with Med Pass once a day. In this note, the Dietitian did not request a reweight to check the validity of the weight of 167 pounds and assumed the weight of 153 pounds was not correct. Further review of the weights for Resident #55 showed that no weekly weights were completed from 08/11/25 to 09/05/2025. A review of the Dietary progress note dated 09/09/2025 showed Resident #55 has a significant unplanned weight loss with suboptimal meal intake. Recommend starting Med Pass two times a day to provide an extra 480 calories and 20 grams of protein. It was again recommended to begin weekly weights for weight monitoring. In this note, The Dietitian reported that Resident #55 was tolerating her diet well and accepted the nutritional supplement well in the past. In an interview conducted on 09/10/25 at 9:43 AM with the facility's Dietitian, he stated that he puts the weekly weights in an internal sheet that gets adjusted periodically. This sheet is then given to the Director of Nursing (DON), and the nursing team takes the weights, and the weights are recorded in the electronic system. For any missing weekly weights, he will ask the nursing team. He further acknowledged that Resident #55 had a significant weight loss and was not sure as to why they did not have weekly weights in the system. According to the Dietitian, he assumed that the weight of 167 pounds was accurate for Resident #55 and that the weight of 153 pounds could not have been correct. Since Resident #55 was on weekly weights, he could see any weight loss trend if it happened. In an interview conducted on 09/10/25, at 10:15 AM with Staff A, a Certified Nursing Assistant (CNA) stated that Resident #55 requires assistance with all meals, specifically eating 75% of her meals for breakfast and 100% of her meals for lunch. In an interview conducted on 09/10/25 at 10:20 AM with the DON, she said that the Dietitian (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gives her and the Assistant Director of Nursing (ADON) a list of any residents who need weekly weights, and she splits the assignments between the nursing staff. There are no specific staff members who take the weekly weights. In the past two months, the weekly weights were given to the ADON, and she was in charge of putting the weights in the electronic system. In an interview conducted on 09/10/25 at 10:30 AM, with the ADON, she said that the weekly weights are given to any of the nursing staff or the DON. The Dietitian may ask for specific weights if needed, but she does not put the weekly weights in the computer system. She may remind the nursing staff that the weekly weights need to be done, but she does not oversee the weekly weights.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to follow the professional standards for gastrostomy tube (G-tube) care and management for 2 out of 2 sampled residents (Resident #22 and Resident #52). The findings included: A review of a facility's policy titled, Medication Administration via Enteral Tube, with a revision date of 03/06/19, documented the following: Place disposable under pad or towel around the area of tube to limit spillage. Check for residual. Check for placement. Aspirate gently by pulling back on plunger of syringe plunger to check for stomach contents.1) Resident #22 was admitted to the facility on [DATE] with diagnoses that included Anoxic Brain Damage, Candidiasis, and Quadriplegia.A review of the recent Minimum Data Set (MDS) assessment dated [DATE], under section C of the Brief Interview for Mental Status (BIMS), documented that it was disabled.An electronic review of physician orders dated 08/19/25 revealed the following: Enteral feed every shift. Check for placement every shift. Enteral stoma care every shift. Check residual every shift and notify MD, if greater than 60 ml every shift.A record review of nursing care plan interventions documented to provide local care to G-tube site as ordered and monitor for signs and symptoms of infection.During observation of gastrostomy care on 09/09/25 at 10:25 AM with Staff G, RN on 09/09/2025 at 10:25 AM, she did not place a barrier after disconnecting the feeding tube from the end port of the G-tube, resulting in spillage on resident's right upper thigh. Staff failed to aspirate for residual, and failed to check the G-tube placement. Staff also failed to clean the G-tube tip and the area around the G-tube before putting back the resident's gown and bed cover. It was observed that the G-tube end tip did not have a cap.2) Resident #52 was admitted to the facility on [DATE] with diagnoses that included Cachexia, Muscle Weakness, Contracture of the Right Hand.An electronic review of MDS assessment dated [DATE], documented under Section C that Resident #52 had a BIMS score of 13 indicating she had no cognitive impairment.An electronic record review of physician order dated 06/30/25 documented for enteral, check residual every shift and notify MD if greater than 60 cc every shift.An additional review of a physician order documented Oxycodone 10 mg tablet, to give via PEG tube every 6 hours for chronic pain.During a medication administration observation on 09/10/2025 at 12:37 PM which was performed by Staff I, RN, the following were observed:Staff I, RN, crushed the medication tablet, then poured it into a medication cup. She prepared a cup of water and stated she needed to dilute the medication. She placed them on a Styrofoam tray. Staff entered the resident's room and stated she would perform hand washing.Staff I, RN did not clean the resident's meal table where she placed the Styrofoam tray. Staff donned gloves, but not Personal Protective PPE) gown. The resident raised her head up using the bed remote. Staff placed a syringe contained inside a plastic bag on top of the meal table. She pulled up the resident's gown, exposed the G-tube end tip and removed the detachable cap cover at the end of G-tube.She started to pour water into the G- tube opening without first performing aspiration to check for stomach contents.Staff I, RN did not verify the G-tube placement. She mixed the crushed medication pill with some water and poured the mixed solution by gravity into the resident's G tube using a syringe. When the medication solution was all in, Staff I, RN put the G- tube cap back. She wrapped the G-tube tip with a cotton towel found below the resident's abdomen, lowered the resident's gown, and covered the resident with a blanket. Staff I, RN threw out the Styrofoam tray and the cups used during the medication administration and returned the syringe inside a plastic bag. She removed her gloves and performed hand washing. Staff left the resident's room at 12:45 PM. When she was asked why she did not check the residual, she responded that she checked the residual during 9:00 AM medication administration. She added that checking for residual and G-tube placement is only done in the morning. A review of Resident #52's electronic Medication Administration Record (MAR) revealed there was no documentation of G-tube residual check at 9:00 AM.A further review of MAR revealed a check mark and 2 initials across enteral (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residual check at 12:00 PM, indicating Staff I, RN performed this process as ordered, but it was not observed during this medication administration. Staff stated that this was the only medication administered at 12:00 PM. In an interview with the Director of Nursing (DON) on 09/09/25 at 3:13 PM when she was asked about the process of giving medications through the G-tube, she responded to wash hands, look at the physician order, apply barrier to cover resident, check the placement, pop a plunger from the syringe barrel. She added that the facility's policy for G-tube noted that the Staff must aspirate for stomach contents first and if more than 60 ml was obtained, do not flush the G-tube. She added that the gastric strip is not used in the facility, and the G-tube flushes are accomplished using gravity. The staff change the syringes for flushes every night, the cap is inside the package, and the Staff use them to cap the flushing syringe. She added that the facility staff use whatever G-tube end port cap that came in the package. She added that G-tube end port must be capped at all times.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to follow the professional standards of tracheostomy care and management for 1 of 1 sampled resident (Resident # 22). The findings included: A record review of the facility's policy titled, Tracheostomy Care, with a revision date of 08/2013, documented the following: Assess respiratory distress. a. Measure resident's oxygen saturation with pulse oximeter. b. Listen to lung sounds with stethoscope. c. Observe for asymmetrical chest expansion. A record review revealed Resident #22 was admitted to the facility on [DATE] with diagnoses that included Anoxic Brain Damage, Candidiasis, Quadriplegia and Chronic Respiratory Failure with Hypoxia and Hypercapnia. An electronic review of recent Minimum Data Set (MDS) assessment dated [DATE] under Section C, revealed that the Brief Interview for Mental Status (BIMS) score was disabled. A tracheostomy care observation was conducted on [DATE] at 10:10 AM with Staff I, Registered Nurse (RN) and Staff J, Licensed Practical Nurse (LPN). Both Staff donned on personal protective equipment (PPE) gown and gloves and performed hand hygiene either with hand sanitizer and with soap and water. Staff I, RN stated that the tracheostomy supplies she will be using are not expired. She added she would be using these supplies and dressings, sterile saline plastic containers, sterile T- drain sponges, inner tracheostomy cannula, and tracheostomy care kit. Both Staff had to be reminded to oxygenate the resident before the tracheostomy care. Staff did not apply the oximeter until they were reminded. Staff I, RN stated the oxygen saturation was at 95 %, 5 minutes before the tracheostomy care. Staff did not assess Resident #22's respiratory status by listening to lung sounds and did not observe for chest expansion. Staff did not set up supplies on the sterile field. Both Staff used clean technique in opening supplies like gauze, normal saline and tracheostomy care kit. Staff I, RN picked up the sterile gloves from the tracheostomy kit and donned them. She put a protective chuck over Resident #22's chest and put a T-drain gauze onto resident's neck. She changed the tracheostomy collar and washed her hands. Staff I, RN put on regular gloves and stated she would change the inner cannula. With regular clean gloves, she picked up a square box from the tracheostomy care kit and asked Staff J, LPN to pour normal saline solution into the box. She then placed the box with normal saline solution on top of the table (not a sterile field). Staff J, LPN opened the inner cannula box and put it on the table. The flap of the box went back to its closing position, indicating the sterility of the inner cannula was not maintained. Staff J, LPN did not keep the flap open for Staff I to pick it up using aseptic technique. Staff I, RN picked up the inner cannula using clean gloves (not sterile gloves). She then inserted the inner cannula into the tracheostomy site. Staff I, RN opened the suction tubing kit using clean gloves and picked up the sterile suction tubing. She dipped the tip of the suction tubing into the box with normal saline. She was asked if she will need to use sterile gloves. Staff I, RN opened another package of suction tubing on top of resident's abdomen. The suction kit came with only one sterile glove, so she asked Staff J, LPN to give her another kit. Staff I, RN opened another suction kit on top of resident's abdomen. She had a hard time donning the sterile gloves stating they are too small. The resident had a big cough, and productive light-yellow colored secretions came out and down the gauze pad. Staff I, RN inserted the suction tip inside the inner cannula tube using her right hand (she used the normal saline solution which was opened onto unsterile field). She stated she would keep the right hand sterile, and the left hand clean. There were more secretions that came out and Staff I, RN used the suction tip to suck the outside sections but inserted the suction tip inside the tracheotomy tube again. She was reminded not to do that. Staff J, LPN was reminded to oxygenate the resident. Staff I was reminded to check the oxygen saturation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility also failed to follow a physician order for a seizure medication and failed to follow the professional standards of nursing practice related to the rights of medication administration: the right time for 1 of 25 sampled residents (Resident # 26). The findings included: A review of the facility's policy titled, Oral Administration of Medication, with a revision date of 08/15/19, documented to review Physician's order (1).According to National Institute of Health, Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person to check to see that the medication is correctly prescribed and dispensed before administration. In upholding patient safety, the "five R's" of medication administration are followed.A guiding principle for one of the five rights is of the right time. The right time is ensuring that medications should be prescribed as closely to the time as possible, and nurses should not deviate from this time by more than half an hour to avoid consequences such as altering bioavailability or other chemical mechanisms. https://www.ncbi.nlm.nih.gov/books/NBK560654/Based on multiple clinical studies, including those funded by the National Institutes of Health, levetiracetam (Keppra) and lacosamide (Vimpat) have shown comparable efficacy for treating focal-onset seizures. Key differences lie in their side effect profiles, mechanisms of action, and controlled substance status. Levetiracetam is not a controlled substance while Lacosamide is a schedule V controlled substance indicating a potential for misuse and dependence. It can also cause abnormal heart rhythms. https://pubmed.ncbi.nlm.nih.gov/40119876/1 A record review documented Resident #26 was admitted to the facility on [DATE] with diagnoses that included Seizure, and Cerebral Infarction due to unspecified Occlusion or Stenosis of the Right Anterior Cerebral Artery.An electronic review of the recent Minimum Data Set (MDS) assessment dated [DATE], under Section C of the Brief Interview for Mental Status (BIMS), revealed a score of 13, indicating Resident #26 had no cognitive impairment.An additional review revealed that on 09/10/25 at 11:07 AM, a physician order for Lacosamide oral tablet 50 mg by mouth, two times a day for seizures. An additional review of physician order dated 01/24/25 revealed Lacosamide oral tablet 50 mg by mouth, two times a day for seizures.During a medication administration observation with Staff G, RN on 09/09/25 at 9:44 AM, she stated that she would administer Lacosamide 50 mg for seizure. She added it is scheduled twice daily.A further record review of a paper documentation called Medication Monitoring Control Record (MMCR) for Lacosamide administration during the month of September, it revealed that it was administered with only a 4-hour interval on the following dates: On 09/03/25, 1 (one) pill was administered at 12:35 PM with the second pill administered at 4:32 PM, both by Staff K, LPN, indicating only a 4-hour interval between administrations.On 09/06/25, 1 pill was administered at 11:03 AM, and the second pill at 4:00 PM, indicating only a 5-hour interval between administrations, with both pills administered by Staff I, RN.In a telephone interview conducted with Staff K, Licensed Practical Nurse (LPN) on 09/10/25 at 10:55 AM, she stated that she knew this resident, and is familiar with the anti-seizure medication Lacosamide. When she was asked what time she usually gives a medication that is scheduled twice daily, she responded, I work from 7 AM to 7 PM, so I would give 1 (one) in the morning, and the next dose would be given by the next shift nurses at night. She added that a medication scheduled to be given twice daily must have an 8-to-12-hour time interval. When she was asked about her process of documenting in the Medication Monitoring Control Record (MMCR), she responded that once she took a pill from the locked medication box, she would sign it out from the MMCR and would immediately administer it to the resident. When she was asked if she verifies the physician order for any anti-seizure medications, she responded, I check the orders, When she was asked why she gave Lacosamide for seizure on 09/03/25 at 12:35 PM and at 4:32 PM with only 4-hour interval between administrations, she responded that she did not know she did that. She added that the second dose (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have been given by the night nurse after 8 to 12 hours from the first dose at 12:35 PM. In an interview conducted with Staff I, RN on 09/10/25 at 3:45 PM, she stated that she gave Lacosamide on 09/06/25 both at 11:03 AM and at 3:04 PM, indicating only a 4-hour interval between administrations. She acknowledged that the interval must be between 8 to 12 hours for a BID, or a twice daily scheduled medication. She added that she would pay more attention to physician orders and administer medications on the right time following the physician ordered interval. When she was asked if she reads and verifies the physician orders for medications, she responded, Yes.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to follow the professional standards of practice related to keeping the medication storage room free of facility staff's personal belongings. The facility also failed to ensure medications and supplies are properly stored for 1 of 21 sampled residents (Resident #53). The findings included: A review of facility's policy titled, Medication Supply Storage and Medication Disposal, with an effective date of 11/30/14, documented the following (ff): Central storage of medications is required for prescriptions, prescribed over-the-counter medications and complementary and alternative medicine (CAM). Will be kept in a locked area, in their original labeled container and may not be removed more than 2 hours prior to scheduled administration. 1) During a tour of the medication storage room with Staff G, Registered Nurse (RN) on 09/09/25 at 10:06 AM, it revealed a big black unzipped purse sitting on the counter next to bags of residents' antibiotics. When Staff G, RN was asked why the big black purse was kept inside a medication storage room, she stated that facility staff leave personal items like lunch boxes, and purses inside the medication storage room. She added that staff do not have an area where they can keep their personal items because the facility is very small. The only place where they can keep their purses is inside the medication storage room. In an interview conducted with the Director of Nursing (DON) on 09/09/25 at 10:44 AM, she stated that facility staff are not allowed to keep personal belongings inside the medication storage room. 2) A record review revealed Resident # 53 was admitted to the facility on [DATE] with diagnoses that included Acute Osteomyelitis of the Left Ankle and Foot, Local Infection of the Skin and Subcutaneous Tissue, and Von Willebrand Disease. An electronic record review of the recent Minimum Data Set (MDS) under Section C of the Brief Interview for Mental Status (BIMS) revealed a score of 15 indicating Resident #26 had no cognitive impairment. A review of physician orders dated 09/02/25, documented to: cleanse left posterior-lateral leg with normal saline; apply Calcium Alginate, and abdominal pad; wrap with kerlix and secure with tape 3x a week, prn (as needed), every night shift, every Tuesday, Thursday, and Saturday for wound management. A review of nursing care plan revealed a focus that Resident #53 requires Enhanced Barrier Precautions related to venous wound requiring a dressing/covering and is at risk for Center for Disease Control and Prevention (CDC), Multiple Drug-Resistant Organism (MDRO). During an observation conducted on 09/08/25 at 9:49 AM, Resident #53 was sitting at the edge of his bed. He had a bulky wrapped dressing on his left foot. On the top left side of his meal table together with drinks and food packages was a big plastic bag of dressing supplies. The plastic bag was observed with pink containers of 15 ml normal saline solution, kerlix dressings, abdominal pads, and Vitamin D ointment in sachets. When Resident #53 was asked about the plastic bag of dressing supplies on top of his food, he responded that facility staff leave them there. He added that these dressing supplies are left over from the past dressing changes, and the staff will reuse them on the next scheduled dressing changes of his left foot. In an interview conducted with Staff I, RN, when asked if she keeps dressing supplies and medications at bedside, she responded, No, staff are not permitted to leave any unused dressing supplies and medications at resident's bedside. When she was asked if a resident is allowed to keep dressings and supplies in his room, she responded, No, no resident is allowed to keep dressing supplies and medications in his room. In an interview conducted with Staff J, Licensed Practical Nurse (LPN) on 09/11/2025 at 12:50 PM, she stated that she has been working in the facility for a long time. She stated that the only dressing supplies allowed inside a resident's room are the tracheostomy care supplies. She added that residents are not allowed to keep any medication and dressing supplies inside their rooms. In another interview with Staff J, LPN on 09/11/25 at 11:30 AM, when she was asked about a process the facility follows for a resident with foot dressing changes (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and with left over dressing supplies, she responded, The dressing supplies which are not used during the dressing changes are discarded, they are not put back in the dressing storage carts and are not kept in the resident's room.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to follow the menus and preferences of 3 out of 3 residents observed during dining observations (Resident #34, Resident #1, and Resident #10). The findings included: 1. A chart review revealed that Resident #34 was admitted on [DATE] with diagnoses of dysphagia and anemia. Magic cup (nutritional supplements) two times a day for lunch and dinner was ordered on 05/22/2025. The nutrition assessment dated [DATE] showed the following: Resident #34's Body Mass Index (BMI) was low for age at 16.8, and that weight gain was beneficial to the Resident. Recommendations were made for a large portion of protein with all meals and Magic cup supplements twice a day. In an observation conducted on 09/08/25 at 12:18 PM in the main dining room, Resident #34 was eating the lunch meal. Resident #34's meal ticket showed the following: a pureed diet, large entree portions, pureed broccoli florets, pureed dinner roll, pureed sour cream, orange cake, and a Magic cup supplement. Further observation of the lunch meal showed that the Magic cup was not provided, and only one scoop of the protein was provided on the plate, which was not a large portion. 2. Resident #1 was admitted to the facility on [DATE] with diagnoses of dysphagia, anemia, and parkinsonism. An order noted for regular diet dysphagia, mechanical soft large portions of proteins for lunch and dinner, dated 07/17/2025. In an observation conducted on 09/09/2025 at 12:13 PM in the main dining room, Resident #1 was eating his lunch meal. The lunch meal ticket was noted to have large portions of protein and ground baked ham. The meal plate was noted with only one scoop of meat and not the large portions of protein as ordered. 3. Resident #10 was admitted to the facility on [DATE] with diagnoses of anemia and dementia. An order was noted for dysphagia, advanced texture, regular/thin liquid consistency, and large entree portions with all meals, dated 3/17/2023. The nutrition assessment dated [DATE] showed that Resident #10 is at risk for malnutrition-related dementia, advanced age, limited mobility, chronic disease process, and comorbidities. In an observation conducted on 09/09/2025 at 12:14 PM, Resident #10 was in the dining room eating his lunch meal. The meal ticket was noted with dysphagia, advanced diet with a large entree. The lunch meal was noted with one serving of ground ham, 1/2 cup serving of baked sweet potato, and 1/2 cup of seasoned green beans. The meal plate did not provide the large entree as ordered by the Physician. In an interview conducted on 09/10/25 at 3:30 PM with the kitchen Manager, he stated that the diet aids on the tray line observe to make sure that the correct food items and portions are placed on the meal trays to match the diets on the meal tickets. It is also his responsibility to ensure that the correct items are on the meal trays. When asked about the double portion of meat, they will place two scoops of the meat (3 ounces each) on the meal plates. When the order calls for a large entree, they will provide significant portions of the meat, starch, and vegetables.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 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, interviews, and chart review, the facility failed to provide food in a form to meet the needs of 2 of 2 residents on the Dysphagia advanced diet (Resident #55 and Resident #10). This has the potential to affect three residents on a Dysphagia advanced diet. The findings included: A review of the National Dysphagia Diet Levels was provided by the Kitchen Manager. The following was noted: Level 3 Dysphagia advance is characterized by a mechanical soft texture, such as moistened ground meats and fork-mashable fruits and vegetables. A chart review revealed that Resident #55 was admitted to the facility on [DATE] with diagnoses of Dementia and Dysphagia following a Cerebrovascular Disease. In an observation conducted on 09/08/2025 at 12:13 PM in the main dining area, Resident #55 was eating her lunch meal. The meal ticket was noted as follows: Dysphagia advanced diet, chopped roasted broccoli florets, chopped ground bruschetta chicken, parmesan noodles, dinner roll, sour cream, orange cake, and tea of choice. The meal plate was noted with ground chicken and two large broccoli florets, 2-3 inches in size, that were not fork-mashable. A chart review revealed that Resident #10 was readmitted to the facility on [DATE] with diagnoses of Alzheimer's Disease and Unspecified Dementia. In an observation conducted on 09/08/2025 at 12:20 PM, in the main dining room, Resident #10 was eating his lunch meal. The meal ticket was noted with the following: Dysphagia advanced diet, chopped roasted broccoli florets, ground bruschetta chicken, parmesan noodles, dinner roll, snickerdoodle cookie, 6 ounces of coffee, and 4 ounces of iced tea. The meal plate was noted with ground chicken and two large broccoli florets, 2-3 inches in size, that were not fork-mashable. In an interview conducted on 09/10/2025 at 3:30 PM with the Kitchen Manager, he stated that on the Dysphagia advanced diet, the meat is ground, and the broccoli needs to be chopped because of its texture. This diet is usually for residents who have problems with swallowing. He further said the only way to provide broccoli on this diet is to overcook it, which they do not. The diets are generated by their computer system, and the meal tickets will be printed with the specific diet consistency for each food item. In an interview conducted on 09/10/2025 with Staff M, Speech Language Pathologist, she said that for the Dysphagia advanced diet, the food needs to be chopped up and recognizable. The vegetables need to be cut into bite-sized pieces, and the broccoli needs to be in smaller florets with no stems.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, it was determined that the facility failed to dispose of garbage and refuse properly in 2 of 2 observations. The findings included: A review of the facility's policy titled Solid Waste Management dated 11/30/2014 showed the following: solid waste shall be handled and disposed of in a manner that shall ensure a safe and sanitary facility environment. An observation was conducted on 09/08/25 at 8:39 AM outside the main dumpster. Two large blue dumpsters were partially open, with numerous bags of garbage/trash broken open and spilling their contents outside the dumpsters. Further observation showed garbage, trash, medication containers, and medical waste products on top of the blue dumpsters. Further observations showed protective Equipment, gloves, and surgical masks were noted all around the garbage area. On 09/09/25 at 8:45 AM, an observation was conducted in the outside dumpster area, where one blue dumpster was found to be unsealed and contained garbage bags, food boxes, disposable plates, and other trash. The area around the blue dumpster was noted with dirty gloves and other trash. In an interview conducted on 09/10/25 with the Kitchen Manager at 2:30 PM, he stated that he oversees the garbage dumpster area and cleans around the area. When asked how often they empty the blue dumpster outside, he did not know.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 reviews, the facility failed to follow the Center for Disease Control and Prevention (CDC) guidelines for Enhanced Barrier Precautions (EBP) for 2 of 15 EBP residents (Resident #4 and Resident #22). The findings included: According to the Center for Disease Control and Prevention (CDC), Enhanced Barrier Precautions sign post included the following: Everyone must clean their hands, including when both entering and leaving the room: Providers and Staff must also wear gloves and a gown for the following: high-contact care resident care activities, dressing, bathing-showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting: Device care or use; central line, urinary catheter, feeding tube, tracheostomy: Wound care with any skin opening requiring a dressing. https://www.cdc.gov/long-term-care/facilities/media/pdfs/ 1) A record review documented Resident #4 was admitted to the facility on [DATE] with diagnoses that included Displaced Fracture of Medial Malleolus of Left Tibia, Gastrostomy Status, and Dysphagia, Oropharyngeal Phase. An electronic review of the most recent Minimum Data Set (MDS) assessment, under Section C of the Brief Interview for Mental Status (BIMS), documented a score of 7, indicating Resident #4 had severe cognitive impairment. An electronic review of physician orders dated 09/01/25, documented EBP related to percutaneous endoscopic gastrostomy (PEG) Tube. A further review of the nursing care plan dated 08/06/25, documented a focus on alteration in usual functional performance in mobility/transfer status, related to weakness. One of the interventions was to use a mechanical lift as a transfer device. During an observation conducted on 09/08/25 at 10:48 AM, two staff were not wearing personal protective equipment (PPE) gowns during a resident's mechanical lift transfer. Both exited Resident #4's room, with one staff member pushing the Hoyer lift out and with the other staff who went out with the resident. The Hoyer lift that used during the resident transfer stayed on the hall for the entire time without disinfection during the morning observation. In an interview conducted with Staff F, a Certified Nursing Assistant (CNA) on 09/10/25 at 4:02 PM, when asked why she did not don gown and gloves during the Hoyer lift transfer of Resident#4, she responded that EBP is followed only for residents with PEG tube and ostomy. She added that she did not remember to use gown and gloves during the transfer, but she performed hand hygiene before and after the transfer. When asked if she disinfected the Hoyer lift after resident's use, she responded, No one told me to disinfect the Hoyer lift after resident's use. She added that she has been working in the facility for 1(one) year and she had never disinfected a Hoyer lift or any machine after each resident's use. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of the facility policy titled Infection Prevention and Control Program provided by the Director of Nursing (DON) revised October 2018 documented in the Policy Statement: An Infection Prevention and Control Program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The program is based on accepted national infection prevention and control standards. Review of the facility policy titled Dressings, Dry/Clean provided by the DON revised September 2013 documented in the Policy Statement: Purpose---of this procedure is to provide guidelines for the application of dry, clean dressings. Steps in the Procedure. 2. Arrange the supplies so they can be easily reached. 6. Put on clean gloves. Loosen tape and remove soiled dressing. 7. Pull glove over dressing and discard into plastic or biohazard bag. 18. Discard disposable items into the designated container. Resident #22 was re-admitted to the facility on [DATE] with diagnoses which included Un-stageable Pressure Ulcer of the Sacral Region, Anoxic Brain Damage, Chronic Respiratory Failure, Quadriplegia, Tracheostomy Status, Gastrostomy Status and Hypertension. He had Mental Status indicative of---severe impairment. On 09/10/25 at 9:36 AM an un-stageable Sacral Wound Care dressing change, present upon admission to the facility on [DATE], was observed for Resident # 22 by Staff D, the assigned Licensed Practical Nurse. Staff D, was assisted with the wound care by Staff J, LPN/Unit Manager (UM). Both Staff D and Staff J were observed retrieving personal protective equipment (PPE) from the supply caddy hanging outside door of the resident's room in order to perform this procedure. During the Sacral Wound Care procedure, Staff D was first observed placing the resident's soiled wound care dressing that she had removed from his person and then placing it in the resident's regular trash can, which did not contain a red bag. Next, Staff D was then observed using her soiled gloves from the dressing change, in order to touch the outside and then reach inside in order to retrieve a 4 x 4 gauze pad pack from the clean dressing supply cart, located in the resident's room, without first removing the soiled gloves. On 09/02/25 the Physician's Order documented, Wound Care Procedure read as follows: Cleanse the sacrum with normal saline (NS), apply Collagen wound filler and cover with a dry dressing daily and as needed (PRN) and every other night shift for Wound Management. An interview was conducted with Staff D on 09/10/25 at 10:10 AM, regarding the fact that she was observed placing the resident's soiled wound care dressing that she had removed from his person and then placing it in the resident's regular trash can, which did not contain a red bag. And, the assigned nurse was then observed using her soiled gloves from the dressing change, in order to touch the outside and then reach inside in order to retrieve a 4 x 4 gauze pad pack from the clean dressing supply cart, located in the resident's room, without first removing the soiled gloves and Staff D, acknowledged that she should not have placed the soiled wound dressing in the regular, trash bag and that she should not have touched the clean resident room's dressing supply bin with her used soiled gloved hand. During an interview conducted with Staff J, on 09/10/25 at 10:21 AM regarding her having placed the regular, trash bag, with the soiled dressing, in the regular, trash can, instead of in the Biohazard bin and she acknowledged that she should have placed the soiled dressing, which was in the regular trash bag, into the Biohazard bin. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Sea - Harbor Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Miami Rd Fort Lauderdale, FL 33316	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Resident #22's Enhanced Barrier Precautions (EBP) Care plan initiated 09/08/25 and revised 09/08/25 indicated Focus: Resident requires EBP related to the use of Indwelling device Tracheostomy, is at risk for a Centers for Disease Control (CDC) Multi-drug Resistant Organism (MDRO) infection with a dressing in place. Interventions: Monitor for any signs or symptoms of infection. Goal: Resident #22 will have a reduced risk of obtaining/transmitting a CDC MDRO during review period. Record review of the Resident #22's Pressure Injury Care plan initiated 06/30/25 and revised 06/30/25 indicated Focus: Resident has pressure injury to the Sacrum related to History of Ulcers, Immobility. Interventions: Administer treatments as ordered and monitor for effectiveness. Treat pain as per orders prior to treatment/turning etc. to ensure the resident's comfort. Goal: Resident #22's pressure injury will show signs of healing and have minimal risk of infection by/through review date. The DON further recognized and acknowledged on 09/10/25 at 11:03 AM, that the soiled wound dressing should not have been placed in the regular, trash bag, the assigned nurse should not have touched the clean resident room's dressing supply bin. And, that the regular trash bag with the resident's soiled wound dressing should not have been placed in the regular trash bin the soiled utility room. But, placed in the Biohazard bin.		