STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105611	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Greenacres	6414 13th Rd S Green Acres, FL 33415

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure dignity with dining for 2 of 5 residents sampled for dignity (Resident #160 and Resident #161). The findings included:1.Resident #160 was admitted to the facility on [DATE] with diagnoses that included Encephalopathy, Adult Failure To Thrive, Dementia, and Anxiety. Her Brief Interview for Mental Status (BIMS) was 4 on the admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 06/29/25. This indicated the resident was severely cognitively impaired. A review of the admission MDS also revealed the resident was dependent on eating. Her diet order was a consistent carbohydrate diet, renal diet, dysphagia puree texture, regular/thin liquids consistency. This indicated the resident had difficulty in swallowing.On 07/07/25 at 12:49 PM the surveyor observed Staff D, a certified nursing assistant (CNA) feeding the resident, who was in bed, while standing up. On 07/08/25 at 12:00 PM the surveyor observed Staff E, CNA, feeding the resident lunch standing up. The surveyor asked Staff E if she was aware that she should be sitting down and she stated she was aware. 2. Resident #161 was admitted to the facility on [DATE] with diagnoses that included Wedge Compression Fracture of Unspecified Lumbar Vertebra, Unspecified Injury of Spleen, and Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-dominant side. His BIMS score was 11 on the Medicare 5-day MDS with an ARD of 07/01/25. This indicated he had mild cognitive impairment. The MDS also revealed that for eating, the resident had the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. His diet was Regular, Dysphagia Puree texture with Honey Thickened fluids consistency.On 07/08/25 at 12:03 PM, the surveyor observed Staff F, CNA, feeding resident lunch while standing up. When the Staff F saw the surveyor, he picked up a chair that was across the room and sat down.On 07/09/25 at 2:30 PM an interview was conducted with the Director of Nursing (DON) to discuss the findings.

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 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. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide fingernail care to dependent residents for 4 of 4 sampled residents, Residents #54, #75, #90, #91; failure to shave a resident (Resident #54) ; failure to provide oral hygiene to a resident (Resident #91).The findings included:1.Review of the record revealed Resident #54 was admitted to the facility 04/17/25. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #54 had a Brief Interview for Mental Status (BIMS) score of 13, on a 0 to 15 scale, indicating the resident was cognitively intact.Review of Resident #54's care plan dated 04/18/25 documented Alteration in Usual Functional Performance in self-care related to Deconditioning including an intervention that documented Personal Hygiene-Setup or clean-up assist with 1 assist.A review of Resident #54's task for personal hygiene documented Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene) was reviewed on 07/09/25 and revealed that in a 30 day look back period it was documented as being completed. Observations were conducted on 07/07/25 at 10:43 AM, 07/08/25 at 10:03 AM, 07/09/25 at 10:00 AM and 07/10/25 at 9:57 AM; Resident #54 had long, dirty nails and long unkempt facial hair on all days. During an interview on 07/07/25 at 10:43 AM when asked how his care was, Resident #54 stated his electric shaver was not working and had been asking staff to help him shave his facial hair and had not received any assistance. When asked how often they cut and cleaned his fingernails he stated, they don't. Resident #54 looked at his fingernails and stated, they need to be cut.On 07/08/25 at 10:03 AM, Resident #54 was heard asking a staff member to help him shave and they acknowledged they would help him. Upon entering Resident #54 room he was noted to be visibly upset and frustrated. When asked if staff had taken care of his facial hair and fingernails yet, Resident #54 stated they have not shaved me or cut my nails, all I'm getting is words and no action. The Resident showed the surveyor his nails and stated see how jagged my nails are, I don't care if they charge me I'll pay for it I just want it done; everyone just gives me words but no action.During a follow up interview on 07/09/25 at 10:00 AM, Resident #54 stated that they still hadn't shaved his facial hair, again, he stated, my nails are still jagged and long, they don't take care of me, they don't do anything, all I get is words from everyone.During an interview on 07/10/25 at 10:05 AM when asked who was in charge of resident's nail care, shaving, and oral hygiene, Staff B, Certified Nursing Assistant (CNA) stated, we are, the CNAs. When asked how often each was done, Staff B stated: nail care was every other week, oral care was daily, shaving depended on if the beard was long and when the Resident requested they wanted it done.On 07/10/25 at 10:11 AM, Staff B came to Resident #54's room with the surveyor to address the Resident's concerns. When asked how the Resident's nails and facial hair looked like to Staff B, he acknowledged his nails were long and dirty and agreed his facial hair needed shaving. Resident #54 expressed his frustrations to Staff B and stated he was not getting any care and needed to be shaved.2. Review of the record revealed Resident #75 was admitted to the facility 10/01/24. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #75 had a Brief Interview for Mental Status (BIMS) score of 12, on a 0 to 15 scale, indicating the resident was moderately cognitively impaired.Review of Resident #75's care plan dated 04/15/25 documented Alteration in Usual Functional Performance in self-care related to deconditioning including an intervention that documented Personal Hygiene -Partial/moderate assistance with 1 staff assist. A review of Resident #75's task for personal hygiene documented Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene) was reviewed on 07/09/25 and revealed that in a 30 day look back period it was documented as being completed.Observations were conducted on 07/07/25 at 2:48 PM, 07/08/25 at 10:09 AM, 07/09/25 at 9:00 AM and 07/10/25 at 9:59 AM; Resident #75 had long unkempt nails on all days.During an interview on 07/07/25 at 02:48 PM when asked if she received fingernail care, Resident #75 stated her nails were long and would like them cut.During an interview on 07/10/25 at 10:30 AM, when asked who was in charge of resident's nail care, Staff A, Certified Nursing Assistant (CNA) stated, the nails were cut by CNAs. When asked how often they were taken care of, she stated every month or when I see they are long I will cut them. Staff A was made aware Resident #75 had expressed she wanted her nails cut and came into the resident's room with the surveyor to observe the resident's fingernails. Upon entering, Staff A acknowledged the length of her nails and stated she would take care of them.3. Review of

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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** Based on observations, interview, and record review, the facility failed to implement interventions to monitor behaviors related to antidepressant and antipsychotic medication for 1 out of 5 residents reviewed for Unnecessary Medications (Resident # 58). The findings included: Record review for Resident # 58 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Dementia, a condition characterized by a progressive decline in affecting memory, thinking, language, and behavior, Parkinson's Disease and Bipolar Disorder. Review of Section C of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident # 58 had a Brief Interview for Mental Status score of 12, which indicated that she was moderately cognitively impaired. Review of the Physician's Orders showed that Resident # 58 had an order for Zonegran Oral Capsule 100 milligrams (mg) 1 capsule by mouth two times a day for Agitation. She also had an order for Venlafaxine Oral Tablet 75 MG one time a day for Depression. There was an additional order for Venlafaxine Oral Tablet 37.5 MG. Give 1 tablet by mouth at bedtime related to Major Depressive Disorder. Resident #58 also had Physician orders for Nuplazid Oral Capsule 34 MG. Give 1 capsule by mouth one time a day for Hallucinations, and Mirtazapine Oral Tablet 15 MG. Give 1 tablet by mouth at bedtime for Major depressive disorder. Review of the Medication Administration Record (MAR) for Resident # 58, for July 2025, lacked documentation of behavior monitoring for antipsychotic and psychotropic medication.On 07/09/25 at 2:30 PM an interview was conducted with the Director of Nursing (DON). Discussed with the DON that there was no behavior monitoring for the antipsychotic or psychotropic medication for Resident #58. The DON stated they might have paper monitoring, or it could be on the MAR. AT 3:00 PM the DON stated behavior monitoring would be on the MAR but she did not see behavior monitoring for Resident #58.