| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105631 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aviata at Big Bend | 207 Marshall Dr<br>Perry, FL 32347 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on interviews and record review, the facility failed to protect residents from abuse for 1 of 7 residents sampled for abuse. (Resident #1)The findings include: On 2/10/26 at approximately 12:00 PM, an interview was conducted with Resident #1, who stated that, on 1/19/26, Staff A, Registered Nurse (RN) entered his room speaking loudly, stating that he is a liar and he is going to get her mom written up. Resident #1 went on to state that the Social Worker Aide (SWA) was present and instructed Staff A to leave the room. Resident #1 went on to state he did not receive a bath on 1/19/26 and 2/3/26 and felt he was being retaliated on from Staff A. Resident #1 stated on another occasion after 1/19/26, Resident #5 was in his (Resident #1) room visiting when Staff A entered his room yelling. Staff A stated she heard him talking about her and to keep her name out of his mouth. Resident #1 stated he wrote a grievance on the missing baths and reported the verbal abuse from Staff A to the Administrator and the Director of Nursing (DON).On 2/10/26 at approximately 1:00 PM, an interview was conducted with Resident #5, who confirmed she was in Resident #1's room and Staff A came in Resident #1's room yelling at Resident #1 to keep her name out of his mouth.On 2/10/26 at approximately 1:35 PM, an interview was conducted with Staff C, Unit Manager (UM), who stated Resident #1 reported the alleged verbal abuse from Staff A that occurred on 1/19/26. Staff C, UM stated she reported the incident to the DON.On 2/10/26 at approximately 2:50 PM, an interview was conducted with the SWA who stated, on 1/19/26, she was present in Resident #1's room when Staff A entered the room. The SWA stated Staff A began loudly speaking to Resident #1, saying that he is lying all the time and she is going to tell her mom to get off his slot. The SWA stated she instructed Staff A to leave the room. The SWA stated she felt the incident by Staff A was verbal abuse and reported the incident to the Social Service Director.On 2/10/26 at approximately 3:10 PM, an interview was conducted with the Social Service Director (SSD), who stated on 1/19/26 she reported the verbal abuse to the Administrator.On 2/10/26 at approximately 3:35 PM, an interview was conducted with the DON, who stated he reported the allegation Resident #1 made against Staff A to the Administrator. During the interview, the DON acknowledged that verbal abuse was a form of abuse. On 2/11/26 at approximately 8:20 AM, an interview was conducted with Staff A, who stated on 1/19/26 she was upset because Resident #1 was speaking with the SWA. Staff A went on to state she received a phone call from Staff B, another RN, stating Resident #1 was threatening to call 911. Staff A stated she was angry that Resident #1 was calling 911 and entered Resident #1's room to confront him. Staff A went on to state Resident #1 is a liar. On 2/11/26 at approximately 8:55 AM, an interview was conducted with the Staffing Coordinator, who stated on 1/19/26 she heard the Social Service Director report the verbal abuse to the Administrator.On 2/11/26 at approximately 10:00 AM, an interview was conducted with the Administrator, who stated that, on 1/19/26, it was reported that Staff A allegedly made statements outside of Resident #1's room. The Administrator went on to state on 1/21/26 she became aware of a witness statement made by the SWA who was present in Resident #1's room when Staff A was yelling<br><br>(continued on next page) |

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

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

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | at Resident #1. During the interview the Administrator acknowledged that verbal abuse was a form of abuse.Review of the facility's grievance log revealed Resident #1 did not receive a shower/bath on 1/19/26 and 2/2/26.A review of Facility's Abuse policy (dated 11/16/2022) page #6 of 9 reveals: All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights. Any employee, who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the vents that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Clinical Services is the designated abuse coordinator. (Photographic evidence obtained). |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on interviews and record review, the facility failed to immediately identify and report an allegation of verbal abuse for 1 of 7 residents sampled for abuse. (Resident #1).The findings include:On 2/10/26 at approximately 12:00 PM, an interview was conducted with Resident #1, who stated that, on 1/19/26, the Social Worker Aide (SWA) was present while Staff A, Registered Nurse (RN), entered his room yelling at him. Resident #1 stated he reported the verbal abuse from Staff A and the feeling of retaliation to the Administrator and the Director of Nursing (DON).On 2/10/26 at approximately 3:35 PM, an interview was conducted with the DON, who stated he spoke to the Administrator about the allegation of verbal abuse on 1/19/26 and was under the impression that the Administrator reported to the state agencies on 1/19/26.On 2/10/26 at approximately 4:00 PM, an interview was conducted with the Administrator, who stated she had been informed of the allegation on 1/19/26. The Administrator went on to say she did not report the abuse to the state agency, stating she did not feel it was abuse.On 2/11/26 at approximately 10:00 AM, an additional interview was conducted with the Administrator who is the facility's Abuse Coordinator, stating the abuse allegations should have been reported to the appropriate state agencies on 1/19/26.A review of Facility's records revealed the facility reported to the state agency on 2/10/26. (Photographic evidence obtained).A review of Facility's Abuse policy (dated 11/16/2022) page #6 of 9 reveals: All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights. Any employee, who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the vents that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Clinical Services is the designated abuse coordinator. (Photographic evidence obtained). |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>Based on interviews and record review, the facility failed to ensure a thorough investigation was conducted of the allegation to protect residents for 1 of 7 residents sampled for mandated reporting. (Resident #1)The findings include:On 2/10/26 at approximately 3:10 PM, an interview was conducted with the Social Service Director (SSD) who stated on 1/19/26 she reported the abuse allegations made by Resident #1 to the Administrator, who is also the facility's abuse coordinator, and felt the allegations were verbal abuse and Staff A needed to be suspended. On 2/10/26 at approximately 4:40 PM, an interview was conducted with the Human Resource Director (HRD), who stated on 1/19/26, while in morning meeting, she heard the SSD report the abuse allegations to the Administrator and that Staff A needed to be suspended. The HRD stated she also went to the Administrator and told her Staff A needed to be suspended. The HRD stated she began a workplace investigation on 1/19/26 and Staff A was terminated on 2/9/26.On 2/10/26 at approximately 4:45 PM, an interview was conducted with Resident #1, who stated he told the Administrator and Director of Nursing (DON) he felt like Staff A, Registered Nurse (RN), verbally abused him and that he was being retaliated against. Resident #1 stated he could not remember the exact date, but it was the week of 1/19/26.On 2/11/26 at approximately 10:00 AM, an interview was conducted with the Administrator who stated she had been informed of the abuse allegation on 1/19/26. The Administrator stated she did not suspend Staff A or report abuse to the state agency stating she did not feel it was verbal abuse because Staff A was outside of Resident #1's room. The Administrator stated on 1/21/26 she became aware the Social Worker Aide (SWA) was a witness and Staff A gave a false witness statement. The Administrator confirmed she did not suspend Staff A for abuse or report the allegations to the state agencies. The Administrator confirmed she should have suspended Staff A and reported abuse to the state agencies. Review of the facility's investigation revealed witness statements and interviews dated 1/19/26 indicating knowledge of the alleged verbal abuse. Review of the facility's reports revealed a report was filed with the state agencies on 2/10/26. (Photographic evidence obtained).A review of Facility's Abuse policy (dated 11/16/2022) page #6 of 9 reveals: All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights. Any employee, who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the vents that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Clinical Services is the designated abuse coordinator. (Photographic evidence obtained). |