STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105631	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Big Bend	207 Marshall Dr 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.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interview, the facility failed to maintain a clean and comfortable environment for 7 of 16 sampled occupied resident rooms. (Rooms # 100, #105, #201 #202, #206, #305, and #401)The findings include:room [ROOM NUMBER] On 3/23/26 at approximately 11:30 AM, room [ROOM NUMBER] was observed with a resident on a pillow with numerous small tears and a dinner plate sized hole with exposed inner foam stained brownish yellow. There was no pillowcase on the pillow. The wardrobe was observed to have a door hanging off the hinge with the sleeve of a long-sleeved shirt draped over the top through the gap. The dresser had exposed particle board along the top border of each drawer. The privacy curtain was soiled with multiple reddish-brown splotches. A follow up observation was conducted in room [ROOM NUMBER] with the Staff F/Registered Nurse. The soiled and ripped up pillow was observed resting on the seat of a wheelchair beside the resident's bed. Staff F observed the pillow and stated the damaged and soiled pillow should have been thrown away. A follow-up observation on the dresser and wardrobe was conducted with the Maintenance Director on 2/26/26 at approximately 10:00 AM. The Maintenance Director observed the dresser and stated that they had ordered new dressers and would replace when received. When asked when the order was placed and who placed it, he stated he was not sure. He also observed the broken drawer on the wardrobe and stated that it would be fixed today. A follow-up observation was conducted for the soiled privacy curtain with the Environmental Services (EVS) Director. He stated that today was the assigned day for replacing all the soiled privacy curtains on the hall. room [ROOM NUMBER] On 3/23/26 at approximately 12:15 PM, room [ROOM NUMBER] was observed with the privacy curtain soiled along the outer border from top to bottom with splotches of dried light brown colored fluid. A follow up observation with the EVS director was conducted on 3/26/26 at 10:05 AM. He stated that the privacy curtain would be replaced along with the other soiled curtains on the hall today. room [ROOM NUMBER] An observation of room [ROOM NUMBER] was conducted on 3/23/26 at 11:59 AM. The fitted sheet (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on the resident's bed had a brown substance stain on the right side of the bed. An additional observation of room [ROOM NUMBER] was conducted on 3/23/26 at 03:18 PM, the fitted bed sheet remains with the same brown substance stain as seen on the previous observation. Additional observations on 03/23/26 at 02:46 PM, 3/24/26 at 09:55 AM, and 3/25/26 at 09:35 AM revealed that the bed linens continued to be soiled with a brown substance. An interview was conducted with room [ROOM NUMBER]'s resident at 09:35 AM. The resident stated that the linens get changed while being bathed or when the linens need to be changed. The resident stated that the staff have not offered to change the bed linens. On 3/25/26 at 02:10 PM an interview was conducted with Staff B (Registered Nurse). Staff B stated that each resident has a scheduled bath and shower day. Staff B also stated that when residents are bathed and are out of their beds that beds should be changed. Staff B stated that bed linens are changed when they are visibly soiled. Staff B additionally stated that the resident in room [ROOM NUMBER] is pleasant and hardly refuses care. Staff B stated that the resident is not known to refuse bed linen changes and is compliant with care. Staff B went to room [ROOM NUMBER] and viewed the fitted bed sheet with the brown substance that has been on the linen since Monday 3/23/26. Staff B stated that the resident is out of bed and the bed linens are visibly soiled and the linens should have been changed. room [ROOM NUMBER] An observation of the restroom for room [ROOM NUMBER] was conducted on 3/23/26 at 2:55 PM. The sink faucet in the restroom was discolored and there were several small holes in the bathroom wall. A follow-up observation of room [ROOM NUMBER] was conducted with the Maintenance Director. He observed the sink faucet and stated the sink had calcium build-up and he could probably remove it with cleaner or replace it. He also stated there was a mirror on the wall that fell and left holes in the wall and he would patch them. (Photographic evidence obtained.) room [ROOM NUMBER] An observation of room [ROOM NUMBER] was conducted on 3/23/26 at 2:17 PM. The B bed overbed table was in disrepair and missing the border, exposing rough particle board. The restroom sink faucet handles were discolored. A follow-up observation of room [ROOM NUMBER] was conducted on 3/26/26 at 9:49 AM with the Maintenance Director. He observed the overbed table for 202 B and stated they will replace the table. He also observed the restroom sink faucet handles and stated they were hard water stains and there was no excuse for this. (Photographic evidence obtained.) room [ROOM NUMBER] On 03/23/2026 at 12:10 PM, room [ROOM NUMBER] had bubbled paint all around window and had baseboards in disrepair. The bed's headboard and footboard trim were missing. Tiles below the window were in disrepair. On 03/26/2026 at 9:27 AM, room [ROOM NUMBER]'s bed headboard trim and footboard trim were (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	missing. Wall baseboards were undone and had bubbled paint. (Photographic evidence was obtained.) On 03/26/2026 at 10:10 AM, the Administrator and Maintenance Director entered room [ROOM NUMBER]. Staff E stated he will place the bed's trim today. Staff E further stated bubbled paint and baseboards on wall will be repaired, as well as the tiles below the window. room [ROOM NUMBER] On 03/23/2026 at 2:28 PM, room [ROOM NUMBER] was noted with holes in the block walls and cracked block revealing concrete. Plastic baseboards were both missing and pulled away in more than one place. The bathroom toilet was running and the bowl was dark brown. Patches of bathroom flooring missing or peeled away. Bathroom doorway was rusted on both sides of the jam. (Photographic evidence was obtained) A further observation on 3/26/26 9:15 AM confirmed that all issues were still present. On 3/26/26 at 10:10 AM, an observation wasr conducted with the Administrator and the Maintenance Director. They both stated that the resident will be moved and a total restoration of room and bathroom will be completed, including replacement of toilet.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, staff interviews and record review, the facility failed to develop a smoking care plan to address smoking supervision and assistance requirements for 1 of 3 residents sampled for smoking. (Resident #11)The findings include:Resident #11 was observed smoking in the designated smoking area with staff supervision on 3/24/26 at approximately 1:25 PM and on 3/25/26 at approximately 9:34 AM and 3:33 PM. The facility supplied a resident smoker list on 3/23/26 with Resident #11 on the current list.A review of the resident's care plan revealed no care plan or interventions related to smoking and the resident requiring assistance with personal care due to weakness. A list of the resident's evaluations revealed one smoking evaluation completed on 2/20/26 at 3:39 PM.A review of the resident's progress notes from the Nurse Practitioner, with the date of 12/22/25, revealed the nicotine patch was discontinued due to the resident's smoking.An interview was conducted with Employee J (certified nursing assistant (CNA)) on 3/24/26 at approximately 1:30 PM, who indicated the resident attends the scheduled smoking times on a regular basis and confirmed Resident #11 had a current smoker agreement that was signed by the resident on 2/20/26.An interview was conducted on 3/26/26 at approximately 9:16 AM with the care plan nurse. She confirmed there was no care plans for this resident for smoking, but it should have been added. The care plan nurse indicated a smoking care plan should be placed in the resident's chart upon admission or when the resident starts smoking.A review of the facility policy revealed the facility will evaluate the residents that wish to smoke on admission/re-admission, quarterly, and with a change in condition to determine if assistance or supervision is required for smoking. Also, if a resident is identified during the smoking evaluation to require assistance or supervision with smoking, the center will include the appropriate information in the care plan.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, resident record reviews, and review of the facility's policy and procedure, the facility failed to implement their policy and procedure to ensure residents were provided with education of the risk and benefits of the vaccine and offered the COVID-19 vaccine in accordance with current CDC (Center for Disease Control and Prevention) guidelines for 4 of 5 residents sampled for immunizations. (Residents #20, #28, #29, and #32)The findings include: On 03/24/2026, a record review was conducted for Resident #20. The record revealed documentation on 03/05/2024 that the resident refused the COVID-19 vaccine. There was no documentation to indicate if the resident was provided with education or offered the 2025/2026 COVID-19 vaccine.On 03/25/2026, a record review was conducted for Resident #28 record revealed no documentation on COVID-19 consent, education, or documented offer of the COVID-19 vaccine to Resident #28 since the resident was admitted on [DATE]. There was no documentation indicating Resident #28 was offered the 2025/2026 vaccination.On 03/25/2026, a record review was conducted for Resident #29. Resident #29 was offered the COVID-19 vaccine on 11/21/24. However, there was no documentation of Resident #29 being offered the current 2025/2026 vaccination or offered the booster as per CDC guidelines and facility policy.On 03/25/2026, a record review was conducted for Resident #32. The record revealed a signed informed consent and education on 5/2/24 for the COVID-19 vaccination. However, the resident was not offered the current 2025/2026 vaccination.During an interview with the Infection Prevention and Control Program facility representative (IPCP) on 03/25/2026 at 11:37 AM, she stated that the COVID-19 vaccine is offered to residents upon admission and re-entries during facility assessment. She stated that vaccination administration is followed per facility policy and vaccinations are offered based on resident eligibility and CDC guidelines.An interview with the Regional Nurse Consultant on 03/25/2026 at 02:16 PM revealed that they were unable to locate records for the assessment and offer of the 2025-2026 COVID-19 vaccine for the sampled 4 out of 5 residents. She stated that Residents 32, 29, and 20 were not offered the updated 2025/2026 COVID-19 vaccination since 2024. She also stated that Resident #28 was never offered or assessed for the COVID-19 vaccination since the resident's admission on [DATE]. Staff A states that the facility policy indicates for the facility to follow the updated guidelines for CDC COVID-19 vaccinations.The 2025-2026 COVID-19 Vaccination Guidance, last updated on November 4, 2025, revealed that the COVID-19 vaccination continues to be recommended for individuals residing in long-term care facilities, with emphasis on older adults and those at increased risk for severe illness. The guidelines indicates that all residents should be assessed for vaccination status and offered the updated COVID-19 vaccine based on age, risk factors, and vaccination history. Additionally, current standards reflect that nursing homes are expected to offer COVID-19 vaccination to residents unless medically contraindicated and ensure appropriate educations, access, and documentation of consent or refusal of the COVID-19 vaccine.A review of the facility's policy and procedure titled Coronavirus Disease (COVID-19) - Vaccination of Residents last on revised June 2022. The facility's COVID-19 Vaccination policy was reviewed on 03/25/2026 at 12:17 PM. The policy revealed each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident has already been immunized. The facility policy states vaccine recommendations and schedules are consistent with the Centers for Disease Control Interim Clinical Considerations for the Use of COVID-19 Vaccines in the United States. The facility policy continues to state that booster vaccine doses are provided in accordance with current CDC guidance.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview, the facility failed to ensure a functioning call light system in the bathroom that could be activated from the floor for 2 of 2 sampled residents. (Residents #4 and #23)The findings include:On 3/24/26 at approximately 3:00 PM, an observation of a bathroom shared between Resident #4 and Resident #23 revealed a call light cord approximately 2 inches long by the toilet and not reachable from the floor in the event of a fall.An interview was conducted on 3/24/26 at approximately 3:05 PM with Employee G, Registered Nurse (RN). She confirmed the call light cord was too short to be activated by residents if they were on the floor following a fall. The RN indicated she would submit a work order for maintenance to address the concern.An interview was conducted on 3/25/26 at approximately 9:33 AM with the Maintenance Director that confirmed the call light cord was too short and required replacement. The Maintenance Director indicated the staff should submit work orders when repairs are needed and he had not been notified of the issue.