STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105688	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at the Bay	10300 4th St N Saint Petersburg, FL 33716

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** 46234 Based on interviews and record review, the facility did not ensure preferences were honored and dignity maintained for one resident (#8) out of eight sampled residents. Findings included: An interview was conducted on 2/17/25 at 12:03 p.m. with Resident #8. The resident stated on several occasions she requested to only have female care givers for incontinence care. She said there were some male caregivers she did not want to care for her, and they were often assigned to her. Review of the Admission Record showed Resident #8 was admitted [DATE] and readmitted on [DATE] with diagnoses including fracture of left lower leg, major depressive disorder, and morbid obesity. Review of Resident #8's care plan showed a Focus area: I need assistance with activities of daily living related to atrial fibrillation, fibromyalgia, hyperlipidemia, hypertension, diabetes mellitus type 2, and left lower leg fracture, initiated 6/6/24. Interventions included resident prefers female care givers, updated on 9/3/24. Review of Resident #8's Minimum Data Set (MDS), Section C - Cognitive Patterns, showed a Brief Interview for Mental Status (BIMS) score of 15, indicating she was mentally intact. Review of facility assignment sheets showed the resident was on the assignment of male caregivers on 1/8/25, 1/18/25, 2/14/25, and 2/15/25. An interview was conducted on 2/17/25 at 12:53 p.m. with Staff D, Registered Nurse (RN) and Unit Manager (UM). She said there are a few residents on the unit, including Resident #8, that have a preference for female caregivers. She said Resident #8 is ok with a couple of the male care givers but does not want certain male CNAs. She confirmed Resident #8's care plan said preference for female caregivers. The UM reviewed the facility assignment sheets and confirmed the male staff members assigned to Resident #8 included some of the male providers the resident requested to not have care for her. She stated doing the unit assignments and ensuring the residents who prefer female do not get male providers is a team effort. She said some certified nursing assistance (CNA's) have their normal assignments and she will fill in the open spots with agency nurses or additional staff. She said the nurses sometimes do the CNA's assignments, especially on the night shift. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 2/17/25 at 1:15 p.m. with the Director of Nursing (DON). She confirmed Resident #8 is care planned for female caregivers. The DON reviewed the facility assignment sheets for 1/8/25, 1/18/25, 2/14/25, and 2/15/25 and confirmed the resident was assigned to male caregivers. She also confirmed there were female caregivers available those days. She stated she was not sure what system was in place to ensure the residents preferences were honored related to caregivers. She also said she provided a list to the units of the residents who requested no male caregivers but does not know specifically who verifies it is honored. The DON confirmed it is a problem Resident #8 was assigned male caregivers. An interview was conducted on 2/17/25 at 1:58 p.m. with the Nursing Home Administrator (NHA). She said her expectation would be that a resident's Kardex and care plan showed if a resident had a preference for female caregivers and that preference would be honored. The NHA said the unit manager and clinical leadership team should be ensuring the preference is honored. Review of a facility policy titled Resident Rights, revised 1/2024 showed: Policy Statement Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; e. self-determination i. exercise his or her rights without interference, coercion, discrimination or reprisal from the facility; p. be informed of, and participate in, his or her care planning and treatment

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on interviews and record review, the facility failed to act upon resident's concerns and grievances for two residents (#3 and #8) of seven residents reviewed for grievances. Findings included: 1. During an observation and interview conducted on 2/16/25 at 12:05 p.m., Resident #3 stated she had concerns and filed several grievances related to call lights not being answered timely and her meal tray not always being set up in a way where she could reach it. She reported her concerns to the SSD (Social Services Director). The resident stated the SSD did not come to her with any feedback. She also stated there was a problem with medications, she does not receive her medications in a timely manner, and sometimes they are not available. She stated most recently last week, she did not receive her sleeping pill and it was not re-ordered. The ARNP (Advanced Registered Nurse Practitioner) ordered it the next day. The resident stated she filed a grievance about this. She stated there was a problem with staffing. Either they don't have enough staff or they don't care. Review of the Admission Record for Resident #3 showed an admitted [DATE]. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] showed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating intact cognition. Review of the facility's grievance log dates 12/2/24 to 2/12/25 showed Resident #3 filed three grievances. Review of these grievances showed: - On 12/2/24: Resident stated it took too long to answer the call light. Resident indicated it took 45 minutes for the call light to be answered. Summary of findings: Call lights audits initiated routinely and education provided on the spot if necessary. Summary of action: Call lights audits initiated routinely and education provided on the spot if necessary. - On 2/12/25, Resident #3 filed two grievances: Grievance #1. Resident states during meals, the CNA's (Certified Nursing Assistants) will often put the tray on her bedside table and leave. Many times, she is unable to reach the table or it will get stuck as she can't get the wheels over her catheter tube, or if she is on her side she can't get onto her back in order to sit up and set up her food. Review of this grievance/concern form showed the facility investigation was blank, investigation conclusion was blank, actions completed to resolve the grievance was left blank. - Grievance #2. Resident states the nurses are not applying ointment to her knees TID (three times daily) and did not receive her sleeping pill last night. The resident states that she was told she was out of pills. Also states some nurses yell into her room from the hall rather than walking in and speaking with her and she does not like it. Review of this grievance/concern form showed the facility investigation was blank, investigation conclusion was blank, actions completed to resolve the grievance was left blank. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/16/25 at 2:31 p.m., an interview was conducted with the SSD. She stated department heads were doing call light audits to see how long it took for staff to answer. She stated, We had noticed it had been a slight delay, five to ten minutes, while the CNAs are in the rooms taking care of other residents. She stated the audit was going on prior to this resident submitting the grievance back in December 2024. The SSD stated the resolution was reported to the resident on 12/2/24, but she could not confirm if her issue was resolved. She stated she did not have any documentation for the call light audits or any education provided to staff. On 2/16/25 at 3:16 p.m. an interview was conducted with Staff D, Registered Nurse (RN) Unit Manager (UM). Staff D, RN UM stated they educated the CNAs about call lights and, It was not specific to that grievance. She stated they did not take any action related to these grievances and she was not aware of the grievances for the resident. An interview was conducted on 2/16/25 at 4:35 p.m. with the Nursing Home Administrator (NHA), the Director of Nursing (DON), and the SSD. The SSD stated the grievances come to her by paper and she transfers the grievance form to an electronic report. This report did not have details, such as who received the grievance, who was notified or who investigated the issue. The review of the grievance on 2/12/25 showed the resident stated some nurses yell at her from the hallway. The review showed this grievance was marked compete, but the issue was not addressed. The SSD stated she thought the appropriate department would have addressed the issue and she marked complete, but did not verify. She also stated she did not speak to the resident. The NHA stated that grievance would have been something they needed to address right away and, Staff should not be yelling out to the resident from the hallway. She confirmed this part of the grievance was not addressed. On 2/16/25 at 3:11 p.m., Staff E, Regional Nurse Consultant (RNC) reviewed the grievances and said, I can see the investigation is missing. There is work that needs to be done there. Review of a facility policy titled Resident Rights, dated 1/2024 showed in the Policy Statement, employees shall treat all residents with kindness, respect, and dignity. The Policy Interpretation and Implementation showed federal and state laws guarantee certain basic rights to all residents of this facility. The rights include the resident's right to: u. voice grievances to the facility or other agency that hears grievances without discrimination and without fear of discrimination or reprisal. 48223 2. During an interview on 2/17/25 at 11:55 a.m., the Resident Representative (RR) of Resident #8 stated they spoke to many of the staff, including the NHA, of concerns related to assisting Resident #8 in a timely manner and they haven't fixed anything. During an observation and interview conducted on 2/17/25 at 12:03 p.m., Resident #8 stated having concerns and they filed grievances regarding call lights being answered timely when needing assistance. The resident also stated no follow up has occurred. Review of the Admission Record for Resident #8 showed an admitted [DATE]. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a quarterly MDS assessment dated [DATE] showed Resident #8 had a BIMS score of 14/15, indicating intact cognition. Review of the facility's grievance log dates 12/2/24 to 2/12/25 showed an absence of grievance(s) for Resident #8. During an interview on 2/17/25 at 2:00 p.m., the NHA stated speaking with the RR of Resident #8, although does not remember specifics. The NHA believes a grievance was completed although they did not see the grievance listed on the log. The expectation would be that all grievances are logged and follow up occurs. Review of a facility policy titled Resident and Family Concerns and Grievances Policy and Procedure, not dated, revealed: PURPOSE: To provide for the prompt resolution of medical and non-medical grievances while maintaining confidentiality, in accordance with applicable federal and state statutes and regulations. POLICY: [Facility Name] (the Facility) is committed to providing its residents with exceptional care and services. To ensure the continued provision of such exceptional care and services, the Facility and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (Associates), have an established grievance process to address resident and family member concerns or dissatisfaction about the Facility's provision of care and services. PROCEDURE: I. Filing of Grievances. A. Residents or their family members, guardian, or representative may voice a grievance to the Facility staff in person, by telephone, or via written communication. B. Should a resident require assistance in voicing a grievance, the Facility Associates shall provide any needed assistance to the resident. C. The Facility shall provide the attached Grievance Report Form to facilitate the voicing of a grievance if requested by a resident or family member. II. Documentation of Grievances A. The Facility's Compliance and Ethics Officer or a designated Associate will document and keep a log of all grievances expressed either orally and/or in writing on the day that it is received or as soon as possible after the event or events that precipitated the grievance. III. Investigation of Grievances A. The Facility's Compliance and Ethics Officer shall notify the management or supervisory staff responsible for the services or operations which are the subject of the grievance. The management or supervisory staff will commence a formal investigation of the grievance as soon as is practicable. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV. Responses to and Resolution of Grievances A. The Facility will follow up with resident or their family members, guardian, or representative within 72 hours of the filing of the grievance. B. The Facility will make reasonable efforts to ensure that all grievances are adequately resolved within thirty (30) calendar days from the day the grievance is received. C. The Facility will advise the resident of the outcome of the grievance investigation and shall make reasonable efforts to contact the resident's family members to advise them of the outcome of the grievance investigation. D. The Facility will provide the resident with a written Grievance Decision, which shall include: a. the date the grievance was received; b. a summary statement of the resident's grievance; c. the steps taken to investigate the grievance; d. a summary of the pertinent findings or conclusions regarding the resident's concern(s); e. a statement as to whether the grievance was confirmed or not confirmed; f. any corrective action taken or to be taken by the Facility as a result of the grievance; and g. the date the written decision was issued. E. In the event that the Facility cannot resolve the grievance within thirty (30) calendar days, the Facility will notify the resident, their family members, guardian, or representative of the status and estimated completion date of the grievance resolution. F. The Facility will document all steps of the grievance resolution in the Facility's records, including whether or not the resident/family was satisfied with the resolution. The documentation will be kept for a minimum of 3 years. V. Notification of Grievance Policy A. The Facility will notify residents, individually or through postings in prominent locations throughout the Facility, of the right to file a grievance. The notification must include the following information: a. Grievances may be filed orally or in writing, and may be anonymous; b. Contact information of the grievance official; c. A reasonable expected time frame for completing the review of the grievance; (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Filers have the right to obtain a written decision regarding a grievance; e. Contact information or the relevant state agency or Ombudsman program for filing a complaint.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 48223 Based on interviews, record review, and facility policy review, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for six employees (Staff C, Licensed Practical Nurse and Unit Manager, Staff G, Registered Nurse, Staff H, Certified Nursing Assistant, Staff I, Certified Nursing Assistance, Staff J, Licensed Practical Nurse, and Staff K, Certified Nursing Assistant) of six employee files reviewed. Findings included: Record review of the facility's undated policy titled, Resident Rights to Freedom from Abuse, Neglect, and Exploitation, showed the facility had no procedure for screening of employees or verifying prior employment. During an interview with the Nursing Home Administrator (NHA) on 2/17/25 at 2:00 p.m., the NHA stated the only policy and procedure they have is the one titled, Resident Rights to Freedom from Abuse, Neglect, and Exploitation. Review of Staff C, Licensed Practical Nurse's (LPN's) employee file revealed: Date of Hire (DOH) 12/3/24, with a Level 2 background screening completed prior to employment, but was not added to the Background Clearinghouse until 1/14/25, which would notify the facility if the employee was charged with a disqualifying offense. No reference checks were completed of prior employment history. Review of Staff G, Registered Nurse's (RN's) employee file revealed: DOH 12/10/24, with a Level 2 background screening completed prior to employment, but was not added to the Background Clearinghouse, which would notify the facility if the employee was charged with a disqualifying offense. No reference checks were completed of prior employment history. Review of Staff H, Certified Nursing Assistant's (CNA's) employee file revealed: DOH 2/4/25, with a Level 2 background screening completed prior to employment, but was not added to the Background Clearinghouse, which would notify the facility if the employee was charged with a disqualifying offense. No reference checks were completed of prior employment history. Review of Staff I, CNA's employee file revealed: DOH 2/4/25, with a Level 2 background screening completed prior to employment, but was not added to the Background Clearinghouse, which would notify the facility if the employee was charged with a disqualifying offense. No reference checks were completed of prior employment history. Review of Staff J, LPN's employee file revealed: DOH 9/17/24. No reference checks were completed of prior employment history. Review of Staff K, CNA's employee file revealed: DOH 1/14/25, with a Level 2 background screening completed prior to employment, but was not added to the Background Clearinghouse, which would notify the facility if the employee was charged with a disqualifying offense. No reference checks were completed of prior employment history. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the NHA on 2/17/25 at 11:05 a.m., the NHA stated the expectation is to have the employee's Level 2 background check completed prior to employment, the employee added to the Clearinghouse data base within five days of hire, and reference checks to be completed prior to employment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observations, interviews, and record review, the facility failed to ensure care and treatment was provided in accordance with professional standard of practice related to 1. Failure to ensure repositioning, skin integrity checks, and incontinence care was provided timely for one resident (#3) of three residents sampled, 2. Failure to ensure a lift transfer was conducted per facility protocol for one resident (#3) of three residents sampled, 3. Failure to ensure a call light was within reach for one resident (#7) of seven residents sampled, and 4. Failure to ensure medications were administered per physician orders for one resident (#3) of three residents sampled. Findings included: 1. During an observation and interview conducted on 2/16/25 at 12:05 p.m., Resident#3 stated she was not repositioned timely and she was afraid her wound on her bottom was going to reopen due to lack of repositioning. The resident stated today the CNA (Certified Nursing Assistant) was here last about 10 a.m. Resident #3 stated when she pushed the call light button five minutes earlier and requested to be changed, the aide said no because it was lunch time. The resident stated they do not reposition or toilet during meals and added they should do it before they serve trays. The resident said, When I ask them, they have an attitude. Some of them just yell from the hallway. They won't even come in to see what I need. The resident stated her fear was the wounds would reopen and delay her plan to discharge home. Review of the Admission Record for Resident #3 showed an admitted [DATE] with diagnoses to include urinary tract infection, pressure ulcer of right buttock, stage 3, pressure ulcer of sacral region, stage 4, neurogenic bowel disorder, neuromuscular dysfunction of the bladder and paraplegia, incomplete. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] showed under Section C - Cognitive Patterns, Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating intact cognition. Section GG - Functional Abilities showed the resident had lower extremity impairment on both sides. Under toileting hygiene, the assessment showed the resident was dependent, meaning a helper does all the effort. Section GG also showed the resident was dependent, meaning a helper does all of the effort for sit to lying, lying to sitting on side of the bed, sit to stand, chair to bed transfer, and toilet transfers. The assessment showed to roll left and right, the ability to roll from lying on back to left side, and return to lying on back, the resident required moderate assistance, meaning helper does less than half of the effort. Review of wound care notes dated 1/20/25, 1/27/25, and 2/3/25 showed Resident #3 is being closely monitored for wound care on a regular basis. The notes showed, The area needs continued aggressive offloading. This complex patient does have multiple comorbidities which can affect wound healing . Review of Weekly Skin Observation notes for Resident #3 dated 1/16/25 showed the resident did not have skin integrity issues, with a summary note, treatment in progress for existing wounds. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Weekly Skin Observation notes dated 1/23/25, 1/24/25, and 1/29/25 showed the resident had skin integrity concerns related to a coccyx pressure wound. Review of Weekly Skin Observation notes dated 2/16/25 showed the resident had skin integrity concerns of right buttock excoriation. Review of Wound Observation Evaluations dated 1/27/25, 2/3/25 and 2/10/25 showed the resident was on a turning and repositioning routine due to right buttock wound. Section E - Comment showed offload area. Review of a care plan for Resident #3 initiated upon admission on 1/9/25 showed a Focus: The resident has bowel incontinence related to IBS (irritable bowel syndrome) with interventions to observe pattern of incontinence and initiate toileting schedule if indicate. A follow up interview was conducted with Resident #3 on 2/16/25 at 2:14 p.m. She stated the CNA did not come to change her or turn her and she may have had a bowel movement. She stated when the lunch tray was picked up, the aide stated she would come back and, She never came back. The resident stated there was also an issue with wound care and they sometimes don't do it. The dressing is supposed to be changed daily. She stated she filed grievances regarding the issue. On 2/16/25 at 2:44 p.m., Resident #3 stated she still had not been repositioned or changed. She stated when she put the call light on a third time, someone came and said the aide was out on break. The resident confirmed her aide had not come in yet and she waited to be changed and repositioned since approximately 10 a.m. On 2/16/25 at 3:18 p.m., the resident was observed in her room and an interview was conducted. She stated the CNA just cleaned her and the nurse changed her dressing. Resident #3 was observed crying and emotional. She stated she asked the nurse to take a photo of her wound and it showed new redness and new skin irritation. The resident stated it was because she does not get changed or repositioned in a timely manner. She stated she could help in repositioning but need help to roll. Review of the February 2025 CNA task log for Resident #3 showed on 2/16/25 and 02/17/25, the resident received ADL (activities of daily living) care one time to include personal hygiene, toileting and repositioning - roll left and right. There was no documentation of other times when care was offered or provided. Review of a CNA [name of an informational filing software displaying key patient information] showed under Safety, encourage resident to turn and reposition every two hours. During an interview on 2/16/25 at 3:50 p.m., Resident #3 was observed sitting in her wheelchair. She stated the aide cleaned her up by herself. She told her the skin was dry, and her bottom had dried up bowel movement (BM). The resident stated it was from lying on the poop too long. The resident also stated she does not always have feeling on her lower body and does not always know she had a bowel movement. She stated she depended on staff to check and change her. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 2/16/25 at 4:15 p.m. with Staff B, CNA, who was assigned to Resident #3. She stated she was scheduled to work 7 a.m. to 7p.m. The staff member checked the resident this morning, sometime between 9 a.m. and 10 a.m., and at the time the resident did not have a BM. She also stated she repositioned the resident at that time. Staff B, CNA confirmed she did not change or reposition the resident again throughout the day and said, I was told she would let me know if she needed care. The staff member said when she went to change the resident, she had a BM, it was thick and stuck on her bottom. I used the spray and a lot of wipes. Her bottom was kind of raw. The CNA stated she was trained to check and change the resident but not at is facility. She stated she should have asked the resident if she needed to be changed. An interview was conducted on 2/16/25 at 4:35 p.m. with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The DON stated the resident should be repositioned and turned periodically, at a minimum of every two hours. She stated if the aide needed help, she should get the nurse if a CNA was not available. The NHA said, The resident should not have waited that long. The DON stated she spoke with Staff B, CNA, who confirmed it was approximately 5 hours, from 10 a.m. to 3 p.m. and stated, It is a long wait, not acceptable to us. An interview was conducted on 2/17/25 at 11:30 a.m. with the wound care certified Physician Assistant (PA-C). The PA-C stated the Resident #3 was compliant with care the resident complained about care this past weekend. He said, She showed me a picture of the wound, it was red and inflamed yesterday, not today. She shared some concerns related to repositioning, and expressed fears related to skin breakdown. The PA-C stated the wound was looking good and continues to heal, but he could understand the resident's fear. 2. During an interview on 2/16/25 at 3:50 p.m., Resident #3 stated Staff B, CNA transferred her from the bed to the wheelchair by herself. The resident said, She did not get help. It is nerve-racking, I am not necessarily a small person. I do not want to fall and get hurt. An interview was conducted with Staff B, CNA on 2/16/25 at 4:15 p.m. The CNA stated she did not review Resident #3's plan of care and did not know about the facility's [name of an informational filing software displaying key patient information]. She stated she used a full body sling lift to transfer the resident by herself. The staff member said, she wanted to get out of bed. This place was a mad house. I could not find anyone to help me. I looked out in the hallways. I decided to transfer her by myself. I know I should not have. The CNA stated she was trained to always use two people for full body sling lift transfers. She stated she did not receive education at this facility related to the use of the lift. Review of a CNA [name of an informational filing software displaying key patient information] showed under ADL (activities of daily living), Transfers - mechanical lift with assistance of 2. Review of a care plan for Resident #3 initiated upon admission on 1/9/25 showed a Focus - I need assistance with activities of daily living because of paraplegia, DM2 (diabetes mellitus) HTN (hypertension), gout, chronic a fib (atrial fibrillation), severe morbid obesity, and multi(ple) wounds. Interventions included to anticipate resident's needs, assist me promptly, assist with daily ADL care to ensure needs are met, and transfers - mechanical lift with assistance of 2. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105688	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at the Bay	10300 4th St N Saint Petersburg, FL 33716

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Physical Therapy (PT) Progress Report, dates of service 1/28/25 - 2/10/25, showed under Patient and Caregiver Training: Instructed patient and primary caregivers in safe [brand name of full body sling lift] transfer techniques in order to with 100% carryover demonstrated by primary caregivers. An interview was conducted on 2/16/25 at 4:29 p.m. with the NHA and the DON. The DON stated she heard Staff B, CNA transferred Resident #3 without help and she used a [brand name of full body sling lift] by herself. The DON said, The resident is a two - person transfer. The CNA should have gotten help. The NHA said the CNA should not have done the transfer alone. She said, absolutely not, that was not safe. The DON stated the CNAs should check the [name of an informational filing software displaying key patient information] to know the transfer status, or they could always ask the nurse. On 02/17/25 at 2:37 p.m. the DON stated the facility did not have a policy for ADLs or written expectations for transfers and bowel and bladder care. 3. During a facility tour on 2/16/25 at 8:47 a.m., Resident #7 was observed in her room eating her breakfast, her plate noted almost empty. The resident stated she did not receive any coffee or anything to drink with her breakfast tray. Her cup was observed empty. The resident stated she was trying to reach her CNA but could not because her call light was on the floor, and no one came around. On 2/16/25 at 8:54 a.m. an interview was conducted with Staff F, CNA. He revealed he was unaware the resident's call light was on the floor. He walked around the resident's bed, picked up the call light, and clipped it to her blanket. He stated he passed the trays at approximately 7:15 a.m. and he did not know the resident did not receive coffee. He checked the cup and said, my bad, I'll get her some. The CNA confirmed he did not do rounds or check on the residents who were eating breakfast in their rooms. Review of the Admission Record for Resident #7 showed an admitted [DATE] with diagnoses of dementia, paraplegia, and adult failure to thrive. An interview was conducted on 2/17/25 at 2:15 p.m. with the NHA and the DON. The NHA stated staff should have made sure the resident had a beverage to start with and the CNAs should have been rounding. She stated the call light should have been within reach. 46234 4. Review of Resident #3's February 2025 Order Summary Report showed an order for Zolpidem 10 milligrams (mg), 1 tablet given every night at bedtime. Review of Resident #3's Medication Administration Record (MAR) from 12/15/24 through 2/15/25 showed Zolpidem was signed off as administered every day, with the exception of 2/11/25. On 2/11/25, the medication was documented as see nurse note. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review Resident #3's Controlled Substance Record for Zolpidem from 12/15/24 through 2/15/25 showed the medication was not signed out on 12/19/24 and 1/14/25. Although they were signed off on the MAR, no Zolpidem was dispensed. On 2/10/25, the resident was administered the last Zolpidem tablet out of the bubble pack. On 2/11/25 the resident did not receive the ordered Zolpidem. The nurse progress note dated 2/11/25 at 11:08 p.m. showed, awaiting pharmacy update. An interview was conducted on 2/17/25 at 10:30 a.m. with Staff C, Licensed Practical Nurse and Unit Manager (LPN UM). He said if a resident runs out of medication the facility has an electronic medication dispensing machine. Staff C, LPN UM said if the medication is a controlled substance, they would have called the pharmacy to get a code to dispense the medication. An interview was conducted on 2/17/25 at 10:38 a.m. with a representative from the facility's delivering pharmacy. The representative reviewed Resident 3's medication record and said no one from the facility pulled Zolpidem out of the electronic dispensing machine at the facility from 12/15/24 through 2/15/25 for the resident. The pharmacy said the re-order of Resident #3's Zolpidem was not put in until the evening of 2/10/25, which was when the last tablet was used. An interview was conducted on 2/17/25 at 1:58 p.m. with the DON. She reviewed Resident #3's MAR and Controlled Substance Record. The DON confirmed the MAR showed Zolpidem was signed off as administered on 12/19/24 and 1/14/25 and the Controlled Substance Record did not show the medication was dispensed. Upon review, she also stated Zolpidem should have been reordered when Resident #3 had four or five days' worth remaining, not when she ran out. The DON confirmed documentation showed the resident did not receive her Zolpidem on 2/11/25 as ordered. Review of a facility policy titled Medication Administration and General Guidelines, dated 2024, showed: Policy Medications are administered as prescribed, in accordance with state regulations using good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication, monograph of all medications is available in the [brand name of medication dispensing unit] otherwise authorized personnel should refer to drug reference material provided by the facility. Procedure 2. Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition, or a medication seems to be unrelated to the resident's current diagnosis or condition, the physician is contacted for clarification prior to the administration of the medication. The interaction with the physician is documented in the nursing notes and elsewhere in the medical record as appropriate period (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. Resident not in facility at scheduled dose time, initial dose of antibiotic), the space provided on the front of the MAR for the dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for [as needed] documentation. The physician must be notified when a dose of medication has not been given. If an electronic medical record is being utilized then the caregiver administering the medication will enter the correct documentation that will then be electronically date/time stamped with their initials.