

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105688	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Aventura at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure grievances were documented and/or resolved for the Resident Council, the Food Committee, and six residents (#8, #171, #172, #213, #169, #125) out of thirty-eight residents sampled. Findings included:</p> <p>1. On 8/25/25 at 10:12 a.m., an observation of Resident #171 revealed she was laying down in bed. She said she wanted choices with meals. She said she received chicken on most days of the week. She said she does not get the option of choosing a substitute for the main meal. Resident #171 stated she has told staff and, "Nothing happens." She said she would like a hot dog or hamburger. She confirmed that staff have talked to her about her food preferences and dislikes.</p> <p>On 8/25/25 at 12:05 p.m., an observation of Resident #171's lunch meal was conducted. The resident said she received gravy when her meal ticket indicated a dislike of gravy. She opened the Styrofoam to-go-box which had mashed potato and gravy on top. The meal ticket revealed gravy under dislikes. Resident #171 gave permission to take photo evidence of her meal and meal ticket.</p> <p>On 8/27/25 at 12:09 p.m., an observation of Resident #171 revealed she was sitting up in bed with the bedside table in front of her. Resident #171 said she was supposed to get a chef salad today and it was on her meal ticket. She said she told the certified nursing assistant (CNA) about ten minutes ago but had not received the salad yet. An observation of Resident #171's meal ticket revealed the following, "Standing Orders: &hellip; 3oz[ounce]/2c[cup] Chef Salad (Mo, We, Fr) [Monday, Wednesday, Friday] &hellip;" Resident #171 opened the Styrofoam to-go-box to reveal it was not a salad. She gave permission to take photo evidence of her meal and meal ticket.</p> <p>On 8/27/25 at 12:11 p.m., an observation of Resident #172 revealed he was laying down in bed with a meal tray on the bedside table next to him. He said he received gravy today and it was on his dislikes. He said this has happened before and he had told staff about it. Resident #172 said he does not eat gravy because it bothered his stomach. Resident #172 gave permission to take photo evidence of his meal and meal ticket.</p> <p>A review of Resident #171's admission record revealed an admission date of 3/5/24, with diagnoses to include Type 2 Diabetes Mellitus with unspecified complications, morbid (severe) obesity due to excess calories, and atherosclerotic heart disease of native coronary artery without angina pectoris.</p> <p>(continued on next page)</p>		

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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 6/10/25, &ldquo; &hellip; 1) Reviewed the minutes from April 1th [first] Meeting. The residents talked about the issues that still are happening &hellip; 7) We are still getting tickets wrong. Need to make sure that we check them better. Did inservice with tickets again &hellip; &rdquo;</p> <p>- 7/1/25, &ldquo;&hellip; 1) Reviewed the minutes from June 10th Meeting. The residents talked about the issues that still are happening. &hellip; 7) We are still getting tickets wrong. Need to make sure that we check them better. Did inservice with tickets again &hellip;&rdquo;</p> <p>- 8/5/25, &ldquo;&hellip; 7) We are still getting tickets wrong. Need to make sure that we check them better. Did inservice with tickets again. &hellip; &rdquo;</p> <p>On 8/28/25 at 1:30 p.m., a follow-up interview was conducted with the CDM. He confirmed there are specific concerns that are repetitive every month in the food committee meetings. He said he tried to honor the resident&rsquo;s requests of food choices. He said he takes into consideration the residents and food committee&rsquo;s menu suggestions and tries to get it on the menu within seven days. The CDM said if a resident does not want the main entr&eacute;e, there is an always available menu, and the resident has to tell the CNA. He stated if a resident has a certain preference and/or dislikes, he will resolve it, &ldquo;If he gets the message.&rdquo; He confirmed he is aware of meal ticket accuracy concerns and has conducted audits. He said he has provided in-services and re-education to staff. He said he is going to start writing down grievances but had not done it previously. The CDM stated, &ldquo;I need to get better at documenting.&rdquo; He said he needed to do another ticket audit to make sure the residents are getting items they want and are not getting their disliked food items.</p> <p>On 8/28/25 at 2:33 p.m., a follow-up interview was conducted with the NHA about grievances. She said grievances are discussed in their daily stand-up meetings. She said they receive the grievance, the department directors will handle it, she takes note of it and gets a copy, and she follows up every day on the resolution of the grievance. She said she expected an update on grievances. She said if they don&rsquo;t resolve the grievance immediately, then within five days the grievance should be resolved. The NHA said resident council grievances are handled the same way. Their grievances are brought to morning meeting and given to the appropriate department head. She said the Activities Director runs the resident council meetings and emails the department heads their grievances. She said if they see multiple grievances with the same concerns, they complete an in-service as it&rsquo;s an identified theme. The NHA said the CDM runs the food committee meetings. She said the CDM shares the minutes and if there is a grievance, that is given to Social Services. She said moving forward the food committee&rsquo;s concerns will be documented. The NHA confirmed those grievances were not documented previously.</p> <p>2. During resident council meeting on 08/27/2025 at 11:00AM, Residents # 3 and #131 voiced concerns about the grievance process not being followed properly by the facility. Resident #3 stated when a grievance was ongoing the Resident Council was not kept updated on the grievance and were continuously told it was being worked on. Example given by Resident #131 was at multiple resident council meetings residents voiced their concern with the staff being on personal phones at work while providing resident care. She stated the activities director told them a grievance would be made, but it was never followed up on with the resident council.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- On 4/9/2025 missing hearing aids. Education to staff on storage of hearing aids. Completed 4/10/25.</p> <p>- On 4/24/25 grievance revealed diet slips not being followed. Confirmed and education to the staff completed on 4/30/25.</p> <p>- On 6/1/25 grievance revealed: old water cup in room. Confirmed. Educated staff on hydration policy. Completed 6/6/25.</p> <p>- On 6/3/25 family concerned resident not being assisted with meals. Investigation did not support allegation. Corrective action: monthly meeting with RR and care team. Completed 6/6/25.</p> <p>- On 6/27/25 family concerned as found Resident #213 soaked and stained with urine. Grievance confirmed. Education provided to staff. Completed 6/27/25.</p> <p>- No other grievance were found or provided before for Resident #213.</p> <p>During an interview on 8/28/2025 at 3:41 p.m. the Facility Risk Manager (RM) stated the RR of Resident #213 consistently has concerns and they were valid.</p> <p>Review of the Resident Council (RC) meeting minutes revealed:</p> <p>-RC meeting was held on 3/12/2025 at 10:25 a.m. Old Business: Still seeing bugs and insects on "A" and "D" Units. New Business: Resident states ice cream is melted; Missing clothes or not receiving them in a timely manor. Call lights are not being answered. D-Unit concerned staff not giving baths.</p> <p>-RC meeting on 4/10/2025 at 10:20 a.m. revealed: Old Business: Social Service Consultant advised residents to ask the Certified Nursing Assistant (CNA) who comes in to the room to answer the call light and is not the assigned CNA to please keep the call light on so the correct CNA knows to answer it. "New Business: no new concerns.</p> <p>-RC meeting on 5/7/2025 at 2:01 p.m. revealed: Old Business: Call lights still an issue. New Business: Bugs on D-Unit, showers not occurring as scheduled.</p> <p>-RC meeting on 6/11/2025 at 2:00 p.m. revealed: Old Business: Call lights still an issue. Showers still a concern. New Business: D Unit porch screen needs to be replaced.</p> <p>-RC meeting on 7/9/2025 at 2:15 p.m. revealed: Old Business: showers are still an issue; bugs still on D-Unit; CNAs still on phones while providing care. New Business: CNAs not providing privacy during resident care. Lifts need to be cleaned. Clothing missing.</p> <p>-RC meeting on 8/6/2025 at 2:00 p.m. revealed: Old Business: went over last month grievances and discussed the education and in-services for staff to correct issues. Resident agreed things were "getting a little better." - the lifts machines are still not very clean. Staff are still on cell phones. New Business: Clothing missing; Staff eating in resident areas;</p> <p>Review of the Grievance Logs revealed:</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - Grievance on 3/12/2025 from RC revealed: Call lights not answered. Resolution revealed: Call light audits completed, and lights answered timely. Date written decision was issued: 3/12/2025. - Grievance on 3/12/2025 from RC revealed: Not enough staff. Resolution revealed: Unit is staff according to acuity, facility policy, and regulatory requirement. No other information was completed on the form. - No Grievance from RC meeting on 4/10/2025 was listed on the grievance log nor was a grievance for the April RC meeting provided as requested prior to the exit of the survey on 8/28/2025. - Grievances on 5/8/2025 revealed: RC reports CNAs are on their phones and using earbuds and they don't answer. Grievance was confirmed. Corrective action taken or to be taken: Nursing management team educated on ensuring staff is not using cell [NAME] in resident care areas. dated 5/15/25. - No Grievance from RC meeting on 6/11/2025 was listed on the grievance log nor was a grievance for the June RC meeting provided as requested prior to the exit of the survey on 8/28/2025. - Grievance on 7/10/2025 from RC meeting reveals: lifts need to be cleaned. Grievance was confirmed. Corrective action taken or to be taken: Education provided of cleaning of equipment per policy. Dated 7/18/25. - Grievance on 7/10/2025 from RC meeting reveals: RC reports privacy not being given during care. Grievance was confirmed. Corrective action taken: Staff educated on care and dignity while providing care. dated 7/15/25. - Grievance on 7/10/2025 from RC meeting revealed: CNAs are still using cell phones while providing care. Grievance confirmed. Corretive action: Education provided to staff on use of cell phone. Dated 7/18/25. - No Grievance from RC meeting on 8/6/2025 was listed on the grievance log nor was a grievance for the August RC meeting provided as requested prior to the exit of the survey on 8/28/2025. <p>During an interview on 08/28/2025 at 2:03 p.m. the Social Service Director (SSD) said anyone can complete a grievance. A resident does not have to write the form out. If a resident has a concern that is voiced to a staff member the staff member should complete the form. The form is given to me or the NHA for follow up and tracking. The SSD confirmed no grievances from RC for April, June and August 2025. The SSD stated the grievances appear to be recurring.</p> <p>During an interview on 08/28/2025 at 2:13 p.m. the Social Service Coordinator (SSC) stated Resident #8 usually emails and drops off a copy of the email to document Resident #8's grievances. Confirmed the grievance is not on the log for July and no further documentation was provided prior to survey exit on 8/28/25.</p> <p>Review of the facility's policy and procedure titled Resident and Family Concerns and Grievances, undated, revealed the following: 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.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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 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. 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; 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 (CCG 00506b) 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; 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.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interviews and record review, the facility failed to ensure the revision and/or implementation of a comprehensive care plan was completed for one resident (#213) out of five residents sampled for falls. Findings included: During an interview on 8/25/2025 at 9:05 a.m. Resident #213's representative (RR) stated being concerned with the facility's lack of identification of concerns and follow up on Resident #213's plan of care. Review of the admission Record for Resident #213 revealed an admission date of 11/28/24 with diagnoses to include: Parkinson's disease without Dyskinesia (involuntary erratic movement), without mention of fluctuations; difficulty in walking; unsteadiness on feet; recurrent falls; unspecified Dementia, severe, with other behavioral disturbance; and other co-morbidities. Review of Resident #213's care plan revealed: Focus: date initiated: 11/6/2023 - The staff have identified that I am at risk for falls because of these risk factors: muscle wasting, Impaired cognition, Unaware of safety needs, Dementia, History of falls, Hypotension. I place myself on the floor, states prefers to be on the floor.Goal: date initiated: 11/6/2023 My risks for falls and fall related injuries will be minimized with nursing interventions daily through the next review date. Interventions: 11/6/2023 - Dated initiated:o Encourage and assist resident to toilet before and after meals and at bedtime. Offer urinal as indicated.o I should have sneakers, shoes, slippers with rubber soles or non slip socks when I am out of bed.o Keep frequently used items with in reach: TV remote, tissues, water glass over bed stand and my water glass (unless I need thickened liquids or can't have anything by mouth).o Keep my call light with in reach so I can call for assistance.o Anticipate resident's needs.o Offer/assist with non-skid socks as resident allows 12/12/2023 Date Initiated:o Maintain bed in lowest bed except care. 01/15/2024 Date Initiated:o Remind and encourage resident to use call light. 04/16/2024 Date Initiated:o therapy referral, encourage use of breaks on wheelchair 05/14/2024 Date Initiated:o encourage resident to be in common areas while OOB (out of bed) 05/16/2024 Date Initiated:o family education r/t (related to) not leaving resident unsupervised in the room. 05/26/2025 Date Initiated:o Therapy eval for balance testing r/t Parkinson's Resolved Date: 06/30/2025 06/03/2024 Date Initiated:o encourage use of footrest while in wheelchair o Floor mat(s) to side of bed on floor. 06/05/2024 Date Initiated:o wheelchair modifications as per orders 12/09/2024 Date Initiated:o Bolsters on while in bed scoop mattress o Encourage rest period after breakfast 12/10/2024 Date Initiated:o dyscem to wheelchair cushion 12/18/2024 Date Initiated:o PT eval and tx (treat) prn (as needed) 12/24/2024 Date Initiated:o encourage resident to be OOB while restless 01/01/2025 Date initiated: o assist resident with ambulating short distance during periods of restless. 03/04/2025 Date Initiated:o Will discuss with wife the use of antirroll backs to wheelchair Resolved Date: 06/30/2025 03/10/2025 Date Initiated:o toileting before getting in bed 03/21/2025 Date Initiated:o Offer toileting after Dinner 04/03/2025 Date Initiated:o Environmental review of wheelchair r/t brake function 05/26/2025 Date Initiated:o encourage and assist resident to common areas when out of bed 06/30/2025 Date Initiated:o offer and assist to bed after visits from family Review of Resident #213's medical record from March 2025 to current revealed the following falls: 3/3/2025 at 20:53 - no injury noted - care plan was updated on 3/4/2025. 3/20/2025 18:30 - no injury noted - The care plan intervention implemented on 3/21/25 to toilet after dinner was a duplicate intervention from 11/2023. No new intervention was found. 3/29/2025 09:58 - small laceration above eye - sent to emergency room (ER) - No new care plan intervention was added nor documentation showing care plan review was found. 4/2/2025 18:38 - no injury noted - The care plan was updated on 4/3/25 to check the wheel brakes for function. 5/1/2025 18:20 - no injury noted - No new care plan intervention was added nor documentation showing care plan review was found. 5/25/2025 10:47 - right wrist skin tear, abrasion to right elbow and forearm and bruising to the left upper back, and pain to right side. The care plan intervention implemented on 5/26/2025 was a duplicate intervention from 5/14/2024, and 12/24/2024. No new intervention was found. 5/27/2025 07:54 - no injury noted- No new care plan intervention was added nor documentation showing care plan review was found. 6/28/2025 20:10 - resident sent to ER - The care plan intervention implemented on 6/30/25 was to offer and assist to bed after family visit. 7/1/2025 20:19 - no injury noted- No new care plan intervention was added nor documentation showing care plan review was found. During an interview on 08/28/2025 at 2:22 p.m. Staff GG, Licensed Practical Nurse (LPN)/ Minimum Data Set (MDS) Coordinator confirmed responsibility for ensuring the MDS is complete and assists in the care plan coordination. Staff GG stated being a new employee at the facility but thinks the nurse on the floor will initiate an intervention after a fall, the following work day the Interdisciplinary Team (IDT) will review the fall and ensure the care plan update is completed and accurate.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure adequate supervision and interventions were provided 1) to prevent major injuries for two residents (#213 and #81); and 2) to maintain a hazard free environment for one resident (#55) out of six residents sampled for falls and hazards. Findings included:</p> <p>1) During an interview on 8/25/25 at 9:05 a.m. Resident #213's Resident Representative (RR) stated being upset with the facility at the lack of treatment and identification of concerns regarding Resident #213's falls and answering of call lights. The RR noted on a visit to the facility Resident #213 had a swollen hand and upon notifying the staff, the staff stated, "we did not notice." The RR stated not being made aware of any recent falls.</p> <p>A review of Resident #213's admission Record showed an admission date of 11/3/23 and readmissions on 3/16/25 and 7/9/25 with the following diagnosis: Parkinson's disease, unspecified dementia, adjustment disorder anxiety, unsteadiness on feet, muscle weakness, hypotension, psychotic disorder with delusions due to known physiological condition, age related osteoporosis without pathological fractures, and other co-morbidities.</p> <p>A review of Resident #213's care plan record revealed:</p> <p>• Care plan focus: The staff have identified that I am at risk for falls because of these risk factors: muscle wasting, impaired cognition, unaware of safety needs, dementia, history of falls, hypotension. I place myself on the floor, states "prefers to be on the floor". Date initiated 11/6/23. Goal: My risk for falls and fall related injuries will be minimized with nursing interventions daily through the next review dated. Date Initiated: 11/6/23.</p> <p>• Interventions revealed:</p> <p>o 11/6/23 initiated the following:</p> <p>• Anticipate residents' needs.</p> <p>• Encourage and assist resident to toilet before and after meals and at bedtime. Offer urinal as indicated.</p> <p>• I should have sneakers, shoes, slippers with rubber soles or nonslip socks when I am out of bed.</p> <p>• Keep frequently used items within reach: TV remote, tissues, water glass over bed stand and my water glass (unless I need thickened liquids or can't have anything by mouth).</p> <p>• Keep my call light within reach so I can call for assistance.</p> <p>• Offer/assist with nonskid socks as resident allows.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> o 11/14/23 initiated the following: Floor mats to right and left side while in bed in lowest position as resident allows. o 12/12/23 initiated the following: maintain bed in lowest position except during care. o 1/15/24 initiated the following: Remind and encourage resident to use call light. o 3/20/24 initiated the following: medication review, psychological evaluation & resolved: 6/30/25. o 5/14/24 initiated the following: encourage resident to be in common areas while OOB [out of bed] o 5/16/24 initiated the following: family education r/t [related to] not leaving resident unsupervised in the room. o 6/3/24 initiated the following: <ul style="list-style-type: none"> &sect; encourage use of footrest while in wheelchair &sect; floor mat(s) to side of bed on floor. (repeat intervention) o 6/5/24 initiated the following: wheelchair modifications as per orders. o 12/9/24 initiated the following: <ul style="list-style-type: none"> &sect; bolsters on while in bed, scoop mattress &sect; encourage rest period after breakfast o 12/10/24 initiated the following: non-slip surface to wheelchair cushion o 12/18/24 initiated the following: PT [physical therapy] evaluation and treatment prn (as needed). o 12/24/24 initiated the following: encourage resident to be OOB while restless o 1/1/25 initiated the following: assist resident with ambulating short distance during periods of restless. o 3/4/25 initiated the following: will discuss with wife the use of antiroll backs to wheelchair. resolved: 6/30/25 o 3/10/25 initiated the following: toileting before getting in bed (repeat intervention) o 3/21/25 initiated the following: Offer toileting after dinner (repeat intervention) o 4/3/25 initiated the following: Environmental review of wheelchair r/t brake function <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>o 5/26/25 initiated the following:</p> <ul style="list-style-type: none"> &sect; encourage and assist resident to common areas when out of bed. (repeat intervention) &sect; Therapy eval (evaluation) for balance testing r/t Parkinson's diagnosis. Resolved: 6/30/25 <p>o 6/30/25 initiated the following: offer and assist to bed after visits from family. (repeat intervention)</p> <p>Review of the progress notes revealed:</p> <ul style="list-style-type: none"> &middot; 3/03/25 at 8:53 p.m. Summary for Providers note revealed: Fall, no major injury and provider recommendations: continue to monitor neurological checks; post fall assessment with score of 95 indicated: High Risk (Score 45 and higher) no further notes were found. &middot; 3/20/25 at 6:30 p.m. Summary for Providers note revealed: Fall no major injury; Resident was sitting in wheelchair in front of room, then suddenly stood up while holding onto wheelchair and sat back down, when prompted. Resident attempted to stand up again and slid to the floor onto the buttocks. Resident's head did not hit the floor or met any hard surface. Resident does have a history of falling. No injuries assessed. Vital signs within normal limits. post fall assessment completed with score of 75 indicated high risk. No other documentation was found. Intervention added to care plan was a repeated intervention of offer toileting. &middot; 3/29/25 at 9:30 a.m. Summary for Providers note revealed: Observed resident lying on back on floor near wheelchair. Resident assessed and assisted back to wheelchair. Resident is alert and awake. Laceration noted above left eye. Notifications made. Physician requested for resident be sent to the hospital for evaluation. Returned at 12:28 p.m. No change to the care plan, no notes regarding review of the care plan or note from IDT. &middot; 4/02/25 at 6:38 p.m. Summary for Providers note revealed: resident was found on floor in room, assessed resident and obtained vitals. No complaints of pain and no injuries. fall scale completed score 75 &ndash; High Risk, neuro checks started. Care plan updated 4/3/25 to review the wheelchair for function. &middot; 5/1/25 at 6:20 p.m. Progress note revealed: writer was called into room; resident was lying on right side in front of his wheelchair. Resident was fully dressed including shoes. RR said resident leaned forward and just rolled out of wheelchair and did not hit head. Range of motion in all extremities as before. No injuries noted. At 6:32 p.m. progress note: vitals were taken and were within normal range. Physician contacted, RR was present in room with resident during fall. Plan of care on going. 5/2/25 Progress note: Interdisciplinary Team (IDT) met and reviewed r/t fall interventions to include therapy to eval for balance testing. (resident was on therapy case load since 3/5/25). <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>&middledot; 5/25/25 at 10:40 a.m. Summary for Providers note revealed: Fall: Provider/RR notified. 10:47 a.m. Progress note: Nurse was notified by the aid immediately that the resident fell on the floor after they were done toileting them. When nurse arrived, the resident was found on floor on the right side between the dresser and bed. Resident did not hit head per nurse aid. Resident was on right side and right wrist has a skin tear, forearm, and elbow has an abrasion. Resident complained immediately about pain on right side. Bruise on upper back on the left noted. Family came in within 30 minutes and was given report on what happened, physician notified and new orders/diagnostics ordered.</p> <p>&middledot; 5/27/25 at 7:54 a.m. Summary for Providers note revealed: Fall Provider/RR notified and order to monitor changes. 12:56 p.m. Progress Note revealed: IDT met 5/26/25 and reviewed fall and interventions to encourage/assist resident to common areas when out of bed. (repeated intervention)</p> <p>&middledot; 6/8/25 at 8:45 p.m. Summary for Providers note revealed: skin condition. Provider notified/RR present. 8:35 p.m. progress note revealed: RR informed writer resident had a wound on left heel. Writer went to resident's room and noted left heel with blister like wound. Wound was cleansed with normal saline and topical antibiotic ointment applied and left open to air. No other skin issues were noted.</p> <p>&middledot; 6/28/25 at 8:10 p.m. progress note revealed: writer noted resident was on floor in dining room lying on left side, with face on floor. Resident was assessed and no injuries noted. No open wound noted. Vitals were taken. Physician notified and ordered resident to hospital for evaluation due to unwitnessed fall. RR notified. 8:30 p.m. Summary for Providers note revealed: writer found resident lying on floor in dining room. No open wound noted on resident. Vitals were taken. No complaint of pain. Resident was sent to hospital for evaluation. RR notified. Resident returned 6/29/25.</p> <p>&middledot; 7/1/25 at 8:19 p.m. Progress note revealed: resident seen sitting on floor in front of chair, no injuries noted, vitals within normal limits, neuro checks initiated, physician notified. 8:54 p.m. Summary for Providers note revealed: Physician notified with no new orders.</p> <p>&middledot; 7/2/25 at 1:29 p.m. progress note revealed: patient is status post fall, as needed pain medication administrated, patient took all meds as ordered and is performing at baseline. Area to knee cleansed and dressed as ordered, vitals are within range. Patients assisted with meals, transfers and peri-care.</p> <p>&middledot; 7/5/25 at 12:10 p.m. Progress note revealed: RR notified nurse of hand swelling. Writer noted left hand swelling and discoloration. Physician notified of injury by an unknown etiology and ordered x-ray series. Ice pack was given to resident. Discomfort noted on touch. Will continue to monitor.</p> <p>&middledot; 7/6/25 at 3:55 p.m. progress note revealed: Resident left via ambulance to hospital.</p> <p>&middledot; 7/9/25 at 7:07 p.m. progress note revealed: Resident returned to facility from hospital via stretcher.</p> <p>Review of hospital records revealed:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-x-ray report dated 7/6/25 at 5:47 p.m. revealed: acute mildly displaced intra-articular fracture at the base of the thumb proximal phalanx extending into the MCP (metacarpophalangeal) joint. Resident had a left thumb fracture status post closed reduction and pinning on 7/7/25.</p> <p>-x-ray report dated 7/6/25 at 7:13 p.m.: subacute nondisplaced right sixth through eighth lateral rib fractures. These are single site rib fractures.</p> <p>During an interview on 8/28/25 at 2:22 p.m. the Minimum Data Set Coordinator (MDS-C) stated the care plan is updated the following morning during an IDT meeting. The MDS-C stated not being familiar with Resident #213 and therefore does not want to comment on the resident's care plan. The MDS-C stated the care plan should be reviewed and updated after each fall. A note should be entered into the resident's chart indicating this has been completed, especially if the care plan does not have any changes needed.</p> <p>During an interview on 8/28/25 at 2:30 p.m. the Assistant Director of Nursing (ADON) stated not being familiar with Resident #213 as being new to the facility. The ADON stated the process the nurses complete when a fall occurs is as follows: nurse is notified of the fall and ensures the safety of the resident. Complete an assessment of the resident documents and ensures proper notifications are completed. The nurse should speak with staff/resident/witnesses regarding what happened and document. Complete incident documentation and any other assessments needed, i.e Neuro checks. Then update the care plan. The following day the IDT reviews the information and discusses to ensure interventions are appropriate and document the information.</p> <p>During an interview on 8/28/25 at 2:46 p.m. the facility Risk Manager (RM) stated the expectations for when a resident has an incident is as follows: nurse completes the incident report to include as much information as possible. The care plan is updated at this time. The following day the IDT reviews the information and ensures the care plan is appropriate and documents this review. Sometimes, the nurse does not update the plan of care, and the IDT will need to do this. The care plan is also reviewed during a standard of care (SOC) meeting on a weekly basis. Any resident who has fallen is added to this meeting for follow up for 4 weeks. The SOC would review of the care plan, document discussion and update as needed. The RM stated being familiar with Resident #213. The RM reviewed Resident #213's care plan and confirmed several of the interventions were repeated on different occasions and the absence of a care plan update on 7/1/25. The RM stated the root cause for Resident #213's falls was the resident's Parkinson's and impulsivity. During the interview the RM stated interventions should be added after each fall to reduce the risk of further falls and reduction of potential for injury with the fall.</p> <p>2) On 8/25/25 at 11:56 a.m. Resident #81 was observed lying in bed at approximately knee height. Resident #81 was groomed and clean, non verbal with interaction at this time, no movement was occurring.</p> <p>During an interview on 8/25/25 at 12:00 p.m. Resident #81's alert and oriented roommate stated resident is bed bound and has not been out of bed since the fall. The facility had Resident #81's RR take the resident's wheelchair home.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #81's admission Record showed an admission date of 1/1/22 and readmissions on 3/14/25 with the following diagnosis: unspecified intracranial injury with loss of consciousness of unspecified duration, traumatic brain injury, moderate protein calorie malnutrition, spastic hemiplegia affecting right dominant side, functional quadriplegia, post traumatic seizures, vitamin d deficiency, and other co-morbidities.</p> <p>A review of Resident #81's medical record from 1/1/25 to 2/16/25 did not reveal any incidents.</p> <p>A review of Resident #81's nurse progress note dated 2/17/25 revealed: Writer was notified by CNA that resident had a skin issue to the left lateral leg. Writer observed yellow bruising around the resident's knee and a blue/purple bruise to the lateral left thigh. Resident did not show any signs of pain when assessing the area. UM (Unit Manager) notified. Writer notified the physician no new orders. Writer called POA no answer. Writer left VM (Voice Mail) to callback.</p> <p>A review of Resident #81's nurse progress note dated 2/18/25 revealed: resident seen for follow up related to bruising left lateral knee/thigh. yellow discoloration noted to left medial thigh/ knee and purple bruising 17.0x4.5cm to left lateral thigh. resident moves extremities without difficulty. no s/s of pain or discomfort expressed at this time.</p> <p>A review of Resident #81's nurse progress note dated 2/21/25 revealed: Edema noted to resident's left lower extremity accompanied by redness, area is warm to touch. Norco administered this shift for pain. In house ARNP notified and order received for left lower extremity venous doppler. Requested for doppler. notification with no answer, message left. Will continue to monitor.</p> <p>A review of Resident #81's Physician/Provider progress note dated 2/21/25 revealed: chief complaint/History Present Illness (HPI) relating to this visit: Patient is a poor historian due to cognitive/psychiatric impairment: Chief complaint/Reason for this visit: Follow up visit r/t edema and erythema to left leg. HPI Relating to this Visit: Long-term resident admitted to the facility in January of 2000 dx intracranial injury w/ (loss of consciousness) LOC. Resident seen today at the request of staff. Resident's left leg is warm to the touch and slightly edematous. Resident is largely non-verbal and unable to provide any history as to if an injury occurred. Skin intact without bruising. &hellip; Assessment and Plan: Peripheral edema: Ultrasound of left leg to rule out DVT (deep vein thrombosis)&hellip; Orders for this Visit: Ultrasound of left leg</p> <p>A review of Resident #81's Physician/Provider progress note dated 2/23/25 the provider note revealed: chief complaint/HPI relating to this visit: Patient is a poor historian due to cognitive/psychiatric impairment: Chief complaint/Reason for this visit: Follow up visit r/t edema and erythema to left leg. HPI Relating to this Visit: Long-term resident admitted to the facility in January of 2000 dx intracranial injury w/LOC. Resident seen today at the request of staff. Resident's left leg is warm to the touch and slightly edematous. Resident is largely non-verbal and unable to provide any history as to if an injury occurred. Skin intact without bruising. Ordered ultrasound of left leg. Results were unremarkable. Contacted resident's POA who is aware. No acute issues at this time. &hellip; Assessment and Plan: Peripheral edema: US (ultra sound) results unremarkable Will monitor &hellip;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #81's nurse progress note dated 2/27/25 revealed: Weekly skin evaluation completed. Findings are as follows: Resident's color is normal. Skin is Warm / Dry. Skin Turgor is good. Edema is not present on assessment. It is noted that the resident has skin integrity concerns. The resident does not have any skin issues on bony prominences. The resident does not have any skin issues on the right buttocks. The resident does not have any skin issues on the left buttocks. The resident does not have any skin issues on the right heel. The resident does not have any skin issues on the left heel.</p> <p>A review of Resident #81's progress notes dated 3/6/25 at 20:43 revealed: Skin progress note: Weekly skin evaluation completed. Findings are as follows: Resident's color is normal. Skin is Warm / Dry. Skin Turgor is good. Edema is noted as present. It is noted that the resident has skin integrity concerns. Resident has noted bruise(s).</p> <p>A review of Resident #81's provider note dated 3/7/25 revealed: &hellip; chief complaint/Reason for this visit: Follow up visit r/t edema and erythema to left leg. History Present Illness (HPI) relating to this visit: Long-term resident admitted to the facility in January of 2000 dx intracranial injury w/LOC. Resident seen today at the request of staff. Resident seen previously for assessment of erythema and swelling to left leg. Ultrasound performed, result unremarkable. Resident seen again today at the request of staff. Her left knee is still edematous and tender to touch. Resident is largely non-verbal and cannot provide an accurate history of the injury. &hellip; Assessment and Plan: Peripheral edema: Ok per POA to have x-ray of left knee.</p> <p>Review of the hospital x-ray report dated 3/8/25 at 5:30 p.m. revealed: indication: knee swelling, outside x-ray knee partially viewed femur fracture. Findings: displaced distal third diaphyseal femur fracture. The fracture extent seems to extend into the medial femoral condyle, not well characterized. Recommend dedicated plain film views of the knee as well. The tibia and fibula appear intact.</p> <p>Review of the hospital emergency room physician report dated 3/8/25 revealed: eyes open and grimaces in pain only, &hellip; Left upper extremity: &hellip; limited range of motion (ROM) left shoulder, elbow, wrist, and hand; with no crepitation or deformity noted some contractures &hellip;; Right Upper Extremity: &hellip; limited ROM right shoulder, elbow, wrist and hand; with no crepitation or deformity noted some contractures, &hellip; Left Lower Extremity: &hellip; contracture of the knee bruising about the left thigh I; &hellip; right lower extremity: &hellip; limited ROM right hip, knee, ankle and foot; &hellip; Assessment/Plan: Resident #81 is a [AGE] year old female that is bed ridden with a history of traumatic brain injury nursing home resident that was noted to have a deformity about her left thigh. The left lower extremity is contracted a flexion position. X-rays are completed showed a left distal femur fracture. The family wish operative treatment stabilization of the left femur fracture.</p> <p>Review of the pre-operative report dated 3/10/25 revealed: Operative Indications: Patient is a [AGE] year-old female with a 30-year history of traumatic brain injury. The patient is non-ambulatory and requires maximum assistance for mobilization. Patient currently resides in a skilled nursing facility. Approximately 4 weeks ago the patient potentially fell onto her left lower extremity. The patient exhibited pain and underwent evaluation. &hellip; Attempted closed management was performed however the patient had persistent complaints of pain and the patient ultimately presented to the emergency department on March 8th, 2025. &hellip; treatment option given the patient's current state of pain and difficulty with motion of the left lower extremity, patient is indicated for surgical fixation of the left femur. &hellip;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/27/25 at 3:49 p.m. Staff MM, Certified Occupational Therapy Assistant (COTA) and Staff NN, Physical Therapy Assistant (PTA) both stated not being familiar with Resident #81. Staff MM, COTA stated resident was last on case load for therapy in 12/24.</p> <p>During an interview on 8/27/25 at 4:22 p.m. Staff OO, Certified Nursing Assistant (CNA) stated being familiar with Resident #81. Stated recalling hearing resident #81 fell out of the wheelchair but does not recall anything else regarding the incident. Staff OO, stated not actually seeing Resident #81 fall. Staff O stated not knowing Resident #81 to be restless or move around a lot. Staff OO, CNA worked on 3/6/25.</p> <p>During an interview on 8/28/25 at 8:10 a.m. Staff W, CNA stated not being aware of how Resident #81 was hurt, although hearing the fracture occurred during a transfer. It is very hard with all the new staff; they are unfamiliar with the residents. Staff W, CNA worked on 3/6/25.</p> <p>During an interview on 8/28/25 at 8:15 a.m. Staff PP, CNA stated "oh goodness, I know about the incident, I was almost blamed for it." Staff PP continued to state, having just been reassigned to the unit Resident #81 resides and a CNA who no longer works here reported a bruise on Resident #81. The Director of Nursing (DON) at the time asked me if Resident #81 had fallen, nothing else was inquired. Staff PP stated only hearing about a fall Resident #81 had prior to arrival to the unit. Resident #81's RR told me the orthopedic physician at the hospital told Resident #81's RR the fracture had to occur with a fall. Staff PP stated Resident #81 does not move around in the bed. Resident #81 has not gotten out of the bed since return from the hospital. Was not on the schedule of 3/6/25.</p> <p>During an interview on 8/28/25 at 8:22 a.m. Staff QQ, CNA stated not recalling anything, although it is odd as Resident #81 is total care.</p> <p>During an interview on 8/28/25 at 8:35 a.m. Staff S, Registered Nurse (RN) stated being quite familiar with Resident #81 as being the resident's primary nurse. Staff S, RN states not recalling anything, I don't even recall Resident #81 hurting the leg. Staff S, RN stated Resident #81 does not move much.</p> <p>During an interview on 8/28/25 at 8:24 a.m. Staff U, Licensed Practical Nurse (LPN) stated Resident #81 is dependent for all care. Staff U, LPN stated not being employed at the facility for long, and Resident #81 had the fracture before Staff U, LPN started.</p> <p>During an interview on 8/28/25 at 8:38 a.m. Staff T, LPN stated Resident #81 is dependent for all care needs and is bed bound now and does not move much. Staff T, LPN stated not being aware of any prior incidents.</p> <p>During an interview on 8/28/25 at 8:40 a.m. Staff RR, CNA stated not caring for Resident #81 primarily although is familiar. States Resident #81 is totally dependent for care and had heard about the fracture and no one had spoken with Staff RR, CNA about anything, no questions at all.</p> <p>During an interview on 8/26/25 at 5:37 p.m. Staff SS, CNA stated being familiar with Resident #81. Staff S, CNA stated, not knowing directly what happened although did hear Resident #81 fell.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/27/25 at 1:26 p.m. Resident #81's RR was left a voice mail message to return call regarding Resident #81.</p> <p>During an interview on 8/27/25 at 4:28 p.m. Staff TT, CNA stated being familiar with Resident #81 and has provided care for resident. Resident #81 is dependent for all care and does not move much as is contracted. Staff TT, CNA stated Resident #81 used to get up in a wheelchair but does not any longer, &ldquo;odd if you were to ask me&rdquo;. Staff TT, CNA states not knowing anything about what happened.</p> <p>During an interview on 8/28/25 at 9:29 a.m. the RM stated as the RM role April 25 and therefore is not directly familiar with Resident #81's incident. The RM did review the facility's file regarding Resident's 81's fracture. The facility had completed an investigation regarding the bruise to resident #81's leg 2/17/25, the bruise was reported on the left lateral side of the back of the knee. The facility determined the bruise was from spastic left sided hemiplegia. No statements or other documents were available for review. The facility closed the investigation on 2/24/25. The RM stated another investigation was completed in 3/25. The RM stated Resident #81 started taking pain medication around the time the bruise was noted, then stopped them a few days later. The RM stated Resident #81 started to take pain medications again and x-rays were ordered with results the resident had a fracture. Resident #81 was sent to the hospital. The RM stated the investigation started in 3/7/25 when the fracture was reported to the facility and was a major injury. The RM stated the staff interview questions were in regards to a fall. One staff interview revealed: DON notified and stated not reportable.</p> <p>During an interview on 8/28/25 at 2:30 p.m. the DON stated just starting and has no knowledge of Resident #213 or #81.</p> <p>During an interview on 8/28/25 at 6:30 p.m. the Nursing Home Administrator (NHA) stated just starting and has no knowledge of Resident #213 or #81.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Aventura at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 4th St N Saint Petersburg, FL 33716	
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy and procedure titled Reporting Accidents and Incidents dated 8/1/2024 showed: INTENT: It is the policy of the facility to report Accidents and Incidents in accordance with State and Federal regulations. PROCEDURE: 1. The Accident and Incident Reporting System will include a comprehensive process which will allow for: a. Collection of the accident and incident occurrence b. Investigation of accidents and incidents c. Evaluation of injuries of unknown source (IUS) d. Tracking and trending of accidents and incidents 2. The Incident Report will be completed by the Nurse assigned to the resident at the time of the event. 3. The Investigation will be completed by the Nurse Manager, or designee, within 72 hours from the event. 4. The IUS Tool will be completed by the Nurse Manager, or designee, within 72 hours from the event. 5. The Director of Nursing Services, or designee, will add the investigation results into the Risk Management system. 6. The Director of Nursing Services, or designee, will track accidents and incidents on the facility surveillance log to determine patterns and trends. 7. Monthly during the facility Risk Management Quality Assurance Meeting, the results of the Accident and Incident Tracking System will be evaluated. 8. The facility will ensure that: a. The resident environment remains as free from accident hazards as is possible. b. Each resident receives adequate supervision and assistance devices to prevent accidents. &hellip; 9. The facility will provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes: a. Identifying hazard(s) and risk(s); b. Evaluating and analyzing hazard(s) and risk(s); c. Implementing interventions to reduce hazard(s) and risk(s); and d. Monitoring for effectiveness and modifying interventions when necessary. 10. The facility will identify each resident at risk for accidents and/or falls, and adequately plan care and implement procedures to prevent accidents. 11. The facility will ensure each resident receives adequate supervision and assistive devices to prevent accidents. &hellip; 13. The facility will develop and implement an accident and incident reporting system that will report adverse incidents to the Administrator, or to his or her designee. 14. The reporting system will consist of: a. Report all alleged violations and all substantiated incidents to the state agency, and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation; b. Report to the State nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service; and c. Analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences. d. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. &hellip; 16. The facility will conduct an internal risk management and quality assurance program to include the use of incident reports to be filed with the risk manager and facility administrator. The risk manager shall have free access to all resident records of the licensed facility. The incident reports are part of the work papers of the attorney defending the licensed facility in litigation relating to the licensed facility and are subject to discovery but are not admissible as evidence in court. 17. A person filing an incident report is not subject to civil suit by virtue of such incident report. As part of the internal risk management and quality assurance program, the incident reports shall be used to develop categories of incidents which identify problem areas. Once identified, procedures shall be adjusted to correct the problem areas. 18. The facility will, for purposes of reporting to the agency, use the t</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure sufficient staff were available to meet the needs of the residents on four units (A, B, C and D) out of four units in the facility. Findings included:</p> <p>An interview was conducted on 8/25/25 at 10:42 a.m. with Resident #216. He/she said when the call light is pressed it can be an hour to an hour and half before someone comes to assist. Resident #216 said he/she had to call the receptionist at the front desk and ask them to call the nurses' station to get help. The resident said even then, it took another 20 minutes before a staff member made it to the room to assist. The resident said he/she is unable to do anything without assistance.</p> <p>Review of admission Records showed Resident #216 was admitted on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction.</p> <p>Review of Resident #216's Brief Interview for Mental Status (BIMS), dated 8/25/25, showed a score of 15, indicating he/she was cognitively intact.</p> <p>An interview was conducted on 8/25/25 at 11:03 a.m. with Resident #169. He/she said call lights are not answered quickly, and he/she often had to wait 40-50 minutes until someone came to assist.</p> <p>Review of admission Records showed Resident #169 was admitted on [DATE] with diagnoses including angina pectoris, heart failure, unsteadiness on feet, and dependence on supplemental oxygen.</p> <p>Review of Resident #169 admission Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, showed a BIMS score of 15, indicating he/she was cognitively intact.</p> <p>An interview was conducted on 8/25/25 at 5:01 p.m. with Resident #52. The resident said he/she had to wait two hours for assistance going to the bathroom. Resident #52 said it didn't make them feel very good and was aggravating. He/she said they almost had an accident having to wait so long. Resident #52 said he/she often had to sit in the chair because there was not enough staff to assist her to bed.</p> <p>Review of admission Records showed Resident #52 was admitted on [DATE] with diagnoses including displaced fracture of upper end of left humerus, muscle weakness, difficulty walking, unspecified fall, and need for assistance with personal care.</p> <p>Review of Resident #52's BIMS, dated 8/13/25, showed a score of 9, indicating moderately impaired cognition.</p> <p>An observation was conducted on 8/28/25 at 10:56 a.m. in the C-wing television (tv) room. Three residents were observed sitting in the tv room with no staff present. One resident was observed attempting to stand up out of her wheelchair and was very unsteady. A second resident was observed trying to leave the tv room by self-propelling his wheelchair, however the wheels were locked, and he struggled to move. No staff were present to assist these residents, however, two staff members passed by the tv room in a hurry and did not stop to assist the residents.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Resident Council (RC) meeting minutes revealed:</p> <ul style="list-style-type: none"> - RC meeting was held on 3/12/2025 at 10:25 a.m. New Business: Call lights are not being answered. - RC meeting on 4/10/2025 at 10:20 a.m. revealed: Old Business: Social Service Consultant & Discussed advice for residents to ask the CNA who comes in & is NOT their CNA to please keep the call light on so the correct CNA knows to answer it. Discussed that ALL CNAs are able to assist w/ [with] care to any resident! - RC meeting on 5/7/2025 at 2:01 p.m. revealed: Old Business: Call lights still an issue. - RC meeting on 6/11/2025 at 2:00 p.m. revealed: Old Business: Call lights still an issue. <p>During an interview on 8/25/25 at 9:05 a.m. Resident #213's Resident Representative (RR) stated being upset with the facility at the lack of treatment and identification of concerns regarding Resident #213's falls and answering of call lights. Resident #213's RR stated call lights especially on the weekends would go unanswered for long periods of time for someone to respond.</p> <p>During an interview on 8/27/25 at 4:22 p.m. Staff OO, Certified Nursing Assistant (CNA) stated we are used to the staffing challenges, &it is what it is&; hard to get everything completed, especially on the weekends.</p> <p>During an interview on 8/28/25 at 8:10 a.m. Staff W, CNA stated trying to accomplish tasks is difficult with staffing the way it is, never know how many residents you have to take care of etc. There are a lot of call offs.</p> <p>During an interview on 8/28/25 at 8:15 a.m. Staff PP, CNA stated staffing is &hit or miss, you just never know.&</p> <p>During an interview on 8/28/25 at 8:40 a.m. Staff RR, CNA stated staffing has been an issue here for a while, we just get used to it.</p> <p>During an interview on 08/25/2025 at 12:53 p.m. Staff V, CNA stated not having enough staff to accomplish our tasks, especially with meal pass.</p> <p>During an interview with the Staffing Coordinator (SC) on 8/28/25 at 2:31 p.m. stated being responsible for assisting in scheduling staff for the facility. The NHA and DON has instructed me to staff the facility predominately by numbers. The SC stated if the facility is not going to have the staff available, &I tell the DON and sometimes we don't meet the requirements, especially on weekends.&</p> <p>During an interview on 8/28/25 at 3:55 p.m. the DON stated the facility is staff on a daily basis to meet the needs of the residents, mostly by numbers for CNAs. The DON stated the facility meets the per patient day (PPD) levels, although we struggle at times especially with the 3 p.m. to 11 p.m. shift, we utilize agency so the numbers are not an issue. The facility reviews staffing daily with the NHA and SC to discuss any staffing concerns. The DON stated not being aware of any staffing concerns.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/28/25 at 4:45 p.m. the NHA stated the SC reports the daily how the scheduling of the facility is doing. The NHA stated only the SC and DON participate in the meeting to determine if the facility is being staffed appropriately.</p> <p>A review of the facility's policy and procedure titled Staffing with a revised date of 8/2022 revealed: Policy Statement: Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. Policy Interpretation and Implementation 1. Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services. 2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. 3. Other support services (e.g., dietary, activities/recreational, social, therapy, environmental, etc.) are also staffed to ensure that resident needs are met. 4. Direct care staffing information per day (including agency and contract staff) is submitted to the CMS payroll-based journal system on the schedule specified by CMS, but no less than once a quarter. 5. Inquiries or concerns relative to our facility's staffing should be directed to the administrator or his/her designee.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure 1) A clean and sanitary kitchen where food is prepared and served; and 2) an operating dish washing machine on a consistent manner observed during the four days of survey in the facility kitchen. Findings included: -On 8/25/2025 at 9:20 a.m. the kitchen was entered and toured with the Kitchen Manager. Upon entering the space, there was a clean handwashing sink with a soap dispenser and a paper towel holder. No trash can to dispose of the used paper towels was observed. There was no trash can anywhere within a twenty-five to thirty foot span to dispose of used paper towels. The Kitchen Manager revealed he did not know where the trash can went and left the space to find another one. He returned with a large tan trash can with a lid that was able to be opened with a foot pedal device. The trash can was visibly used and half full with refuse. The top of the trash can lid was observed with red and brown sticky substances, as well as along the left side of it. Photographic evidence was taken. The immediate area of the clean hand washing sink to include the walls on the right and left side, the floor tiles just below, were observed with new and old food debris, as well as compressed piles of dust and debris. The immediate space of the hand washing sink was observed soiled. Photographic evidence was taken. -The food service/food preparation area to include the steam table and cooking area, was observed with a long line of dust and debris hanging from the ceiling and light fixture. It was observed the dust and debris build up was directly over food preparation areas, food holding areas, as well as food serving areas. Photographic evidence was taken. -The ceilings and walls near the three compartment sink area, as well as above a two compartment sink near the dish washing machine area revealed brown sticky spotting that appeared to be food debris, or liquids. The spots were observed again during tours on 8/26/2025 at 8:30 a.m. and again on 8/27/2025 at 11:00 a.m. On 8/27/2025 at 1:50 p.m. an interview with the Kitchen Manager revealed the kitchen supports a daily cleaning schedule and stated daily cleaning assignments include the cleaning of walls, floors, cooking and food preparation equipment, as well as food service equipment. He revealed generally the entire kitchen space is cleaned between all meal services. The Kitchen Manager confirmed the observed areas of concern to include liquid and food debris spotting on the walls and ceiling, heavy dust and debris on the ceilings and ceiling vents above food cooking and food preparation stations, and various other soiled areas. The Kitchen Manager revealed the ceiling cleaning maintenance is the responsibility of the Maintenance department and he believed Maintenance will clean the ceilings and vents once monthly. During a telephone interview on 8/26/2025 with a family member related to Resident #8, as well as a documented complaint dated 7/9/2025, it was revealed the family had concerns with the facility's dish washing machine and residents were being provided with Styrofoam containers, and paper and plastic eating utensils for all three meals, every day, since 7/9/2025. She stated she had been told the kitchen had lost a staff member and the machine had broken down. She was not given timeframes of when the machine would be operating again. Resident #8's family member was concerned the residents in the building were not being provided with regular eating ware to provide a good homelike and dignified eating experience and this had been going on for well over one month. On 8/25/2025 at 9:20 a.m. a tour was conducted with the Kitchen Manager. He revealed they have a High Temperature dish washing machine but it was currently not operating and had not been working for some time. The Kitchen Manager revealed they are utilizing the three compartment sink to wash pots and pans and adaptive eating equipment, but are giving residents paper and plastic eating utensils and Styrofoam containers to eat with during all three meal services. The Kitchen Manager revealed the dish washing machine had not been working for over a month and a half, but did not know the exact date when it first broke down. He stated they have worked with the Maintenance department and the Maintenance Director has communicated with the outside sourced dish machine repair company and he believes they are still awaiting parts. The Kitchen Manager stated it has been a long time where residents were using paper, plastic and Styrofoam for all their meals and he understands some have been complaining of the continued use. The Kitchen Manager did not know if the Nursing Home Administrator and Activities staff have notified the residents of the broken down machine, nor did he know if the residents were provided with continual status on when the machine would be fixed and when they would be able to use regular eating ware. On 8/25/2025 at 11:25 a.m. an interview with the Nursing Home Administrator (NHA) and Maintenance Director both confirmed the kitchen has been having some ongoing problems with the dish washing machine which has made it inoperable. The Maintenance</p>		