

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 11/17/2025
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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 11/17/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations, interviews and record review, the facility did not ensure the physician was notified of missed doses of pain medications for one resident (#3) out of three residents sampled. Findings included: On 11/17/25 at 10:37 AM, Resident #3 reported waking up in the middle of the night in pain. The resident reported she calls the night nurse to ask if her scheduled pain medications could be administered. The resident stated there were concerns with the nurse being unresponsive to her request. On 11/17/25 at 2:03 PM Resident #3 stated that on the nights of 11/14/25 and 11/15/25 they woke up in pain in the right arm around 2:00-3:00 AM and called their night nurse to inquire if the scheduled pain medications could be received. Resident #3 stated being on a strict regime of every 4 hours to receive their pain medications to prevent oncoming pain per doctor's orders. Resident #3 said being on a consistent schedule with their pain medications helps to prevent them from feeling any additional pain. Resident #3 stated to strongly preferring for nurses to wake them up to take the scheduled pain medications in order to have prevented the pain. The resident said she was always talking about wanting to be woken up and doesn't mind being woken up to take their pain medications. A review of Resident #3's admission record revealed an admission date of 7/30/25 with a medical diagnosis of seizures, muscle weakness, anxiety disorder, major depressive disorder, and post concessional syndrome. A review of Resident #3's orders revealed that starting on 10/27/25, the resident is to start Hydrocodone-Acetaminophen Oral Tablet 7.5-325 MG (Hydrocodone-Acetaminophen) with one tablet scheduled for every 4 hours to prevent pain. A review of Resident #3's care plan revealed no documentation related to refusing medications or to not be woken up in order to receive scheduled medications. A review of Resident #3's progress notes from 11/7/25 to 11/17/25 revealed no documentation of advising the resident's representative or physician of the missed pain medications. A review of Resident #3's quarterly Minimum Data Set (MDS) assessment, dated 10/30/25, in section C - cognitive patterns revealed a Brief Interview Mental Score (BIMS) of 15. A review of Resident #3's Medication Administration Record (MAR) for dates of 11/1/25 to 11/30/25 revealed that the resident did not receive their hydrocodone 2:00AM dose on the nights of 11/14/25 and 11/15/25. The reasons for the medication not being administered is because the nurse documented Resident #3 as sleeping for both attempts. On 11/17/25 at 2:12 PM an interview was conducted with Staff A, Licensed Practical Nurse (LPN). Staff A, LPN said if a resident is sleeping at the time of medication administration, the process is to gently wake up the resident to either give them their medications, or to at least give the resident the opportunity to refuse the medication. Staff A, LPN mentioned that Resident #3 is followed by pain management and uttered the importance of keeping the resident's routine of pain medications in order to prevent pain from coming. On 11/17/25 at 2:40 PM an interview was conducted with Staff B, Unit Manager (UM). Staff B stated there is a high priority to attempt to wake up a resident when they have a scheduled medication to be provided, and to give the resident the opportunity to refuse if they would prefer. Staff B said it is not up to the nurse's discretion to refuse or not provide a resident without their scheduled pain medications. Staff B, UM said that medication was not administered as scheduled for Hydrocodone on 11/14/25 and 11/15/25. On 11/17/25 at 3:25 PM an interview with the Interim Director of Nursing (DON) and the Assistant Director of Nursing (ADON) in training was conducted. The DON stated staff should re-attempt to wake up the resident to administer scheduled pain medications with no specific time frame and also make a note in the resident's progress notes of the attempts. The DON confirmed there was no medication administered to the resident both dates of 11/14/25 and 11/15/25. The DON stated for both missed doses should have been administered to Resident #3 since they were scheduled. The DON said the expectation was for nurses to attempt to wake up the resident. The DON said it was not up to the nurses' discretion on when to and when not to administer medications. A review of the facility's Pain Management Guidelines revealed the following: The facility staff will identify key characteristics of the pain which includes: . iv. Timing. Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or the residents representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission.</p>		

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 11/17/2025
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>(continued on next page)</p>

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 11/17/2025
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations, interviews and record review, the facility did not ensure to advise physicians or family representatives of missed scheduled pain medications for one resident (#3) out of three residents reviewed and sampled. Findings included: Findings included: On 11/17/25 at 10:37 AM, Resident #3 reported waking up in the middle of the night in pain. The resident reported she calls the night nurse to ask if her scheduled pain medications could be administered. The resident stated there were concerns with the nurse being unresponsive to her request. Resident #3 stated being on a strict regime of every 4 hours to receive their pain medications to prevent oncoming pain per doctor's orders. Resident #3 said being on a consistent schedule with her pain medications helps to prevent her from feeling any additional pain. Resident #3 strongly expressed her need for nurses to wake her up to take the scheduled pain medications in order to prevent the pain. On 11/17/25 at 2:40 PM an interview was conducted with Staff B, Unit Manager (UM). The interview revealed the physician must be notified if a medication is missed or refused, and there is a high priority to attempt to wake up a resident when they have a scheduled medication to be provided in order to give the resident the opportunity to refuse if they would prefer. Staff B stated it is not up to the nurse's discretion to refuse or not provide a resident without their scheduled pain medications, the physician must be notified so they can provide instruction on whether to give a staggered dose, or to wait till the next dose to administer to the resident. Staff B stated there is no note or notification sent to the physician or family representative pertaining to the missed doses of Hydrocodone for 11/14/25 and 11/15/25, and they both should have been notified of these incidences since the resident is on scheduled pain medications. A review of Resident #3's admission record revealed an admission date of 7/30/25 with a medical diagnosis of seizures, muscle weakness, anxiety disorder, major depressive disorder, and post concessional syndrome. A review of Resident #3's orders revealed that starting on 10/27/25, the resident is to start Hydrocodone-Acetaminophen Oral Tablet 7.5-325 MG (Hydrocodone-Acetaminophen) with one tablet scheduled for every 4 hours to prevent pain. A review of Resident #3's care plan revealed no documentation related to refusing medications or to not be woken up in order to receive scheduled medications. A review of Resident #3's progress notes from 11/7/25 to 11/17/25 revealed no documentation of advising the resident's representative or physician of the missed pain medications. A review of Resident #3's quarterly Minimum Data Set (MDS) assessment, dated 10/30/25, in section C - cognitive patterns revealed a Brief Interview Mental Score (BIMS) of 15. A review of Resident #3's Medication Administration Record (MAR) for dates of 11/1/25 to 11/30/25 revealed that the resident did not receive their hydrocodone 2:00AM dose on the nights of 11/14/25 and 11/15/25. The reasons for the medication not being administered is because the nurse documented Resident #3 as sleeping for both attempts. On 11/17/25 at 2:12PM an interview was conducted with Staff A, Licensed Practical Nurse (LPN). Staff A, LPN said the physician and family representative must be contacted in order to advise them of the missed medication dose that was scheduled. Staff A, LPN said that if a resident is sleeping at the time of medication administration, the process is to gently wake up the resident to either give them their medications, or to at least give the resident the opportunity to refuse the medication, then to notify the physician and family representative of refused dose if applicable. When a medication is denied or not administered, it must be documented in the resident's progress notes as well. Staff A, LPN stated that Resident #3 is followed by pain management and uttered the importance of keeping her routine of pain medications in order to prevent pain from coming. On 11/17/25 at 3:25 PM an interview with the Interim Director of Nursing (DON) and the Assistant Director of Nursing (ADON) in training was conducted. The DON stated staff should re-attempt to wake up the resident to administer scheduled pain medications with no specific time frame and also make a note in the resident's progress notes of the attempts. The DON confirmed there was no medication administered to the resident both dates of 11/14/25 and 11/15/25. The DON stated for both missed doses should have been administered to Resident #3 since they were scheduled. The DON said the expectation was for nurses to attempt to wake up the resident. The DON said it was not up to the nurses' discretion on when to and when not to administer medications. A review of the facility's Pain Management Guidelines revealed the following: Pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Identify circumstances when the pain can be anticipated. The facility staff will manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and</p>		