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	08/28/2025

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. Based on observations, interviews, and record review, the facility failed to ensure dignity was maintained for residents during dining related to serving residents at a single table meals at the same time in one out of four dining rooms observed. Findings included:An observation was conducted on 08/25/2025 at 12:25 p.m. in the D-unit dining room, two tables were pushed together with six residents seated. Four of the residents had their meals and were eating while the fifth and sixth residents did not have any food or drink. Staff V, Certified Nursing Assistant (CNA) was sitting in a chair at the far end of the table, looking at her hands while holding an electronic device. During an interview on 08/25/2025 at 12:53 p.m. Staff V, CNA stated staff were still passing the trays and the staff pass the trays in room order only. Staff V, CNA stated all residents should be served at the same time at one table, but I am only to watch them. An observation was conducted on 08/28/2025 at 8:00 a.m. in the D-unit dining room, five residents were seated around a table. Three residents had empty Styrofoam containers in front of them and two residents had no food or drink in front of them. Staff W, CNA called to another staff member to bring the two resident trays. At 8:08 a.m. Staff W, CNA served the two residents their trays. During an interview on 08/28/2025 at 8:10 a.m. Staff W, CNA stated the residents should all be served at the same time, but the trays come out in room order. During an interview on 08/28/2025 at 8:35 a.m. Staff S, Registered Nurse (RN) stated residents should be served at the same time when they are seated at the same table.Review of the facility policy and procedure titled Preparing the Resident for a Meal, revised September 2010, revealed the following: Purpose: The purpose of this procedure is to prepare the resident and the environment in order to help make meal time pleasant for the resident.Review of the facility policy and procedure titled Resident Rights, undated, revealed the following: Purpose: To ensure the preservation of every resident's right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Policy: It is [Facility Name] (the Facility) policy that any all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (Associates) must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Procedure: . V. Respect and dignity. Every resident has a right to be treated with respect and dignity, including: .

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure clean and sanitary resident spaces, to include resident rooms and bathrooms and clean and safe resident equipment, during three of four days observed (8/25/2025, 8/26/2025, and 8/28/2025) and in four of four units (A, B Memory Unit, C, and D). Findings included: 1. During a facility tour on 8/25/2025 at 9:50 a.m., 8/26/2025 at 8:10 a.m. and on 8/28/2025 at 8:20 a.m. the following was observed: Resident room [ROOM NUMBER] was observed with a sliding glass door that is not unlockable. The bottom track of the door was observed with a very large water logged white and with rusted spots clogging what appeared to be a water leak. The towel which was heavily water logged, appeared to be in this position for a long period of time. Photographic evidence was taken. Resident room [ROOM NUMBER] bathroom shower stall observed with bio growth on shower tiles and grouting. Photographic evidence was taken. The cubby sitting area in between resident rooms [ROOM NUMBERS] was observed with two chairs blocked by a wheelchair and a mechanical lift. Photographic evidence was taken. Resident room [ROOM NUMBER] was observed with a half full quart of store bought milk positioned on the floor near the closet. Observations were made at 8:10 a.m. and 8:50 a.m. with the quart of milk in the same place. Resident was not in room at the time of both visits. Photographic evidence was taken. Resident room [ROOM NUMBER]a over the bed table was observed with three of the four corners peeled up and leaving non cleanable surfaces. Photographic evidence was taken. Resident room [ROOM NUMBER] bathroom was observed with heavily stained floor tiles at and surrounding the toilet base. The metal piping was observed heavily oxidized and rusting. Photographic evidence was taken. Resident room [ROOM NUMBER]b was observed with a dark red/maroon in color fall floor mat that was peeling and had tears and chunks torn away. This mat was non cleanable. Photographic evidence was taken. The C wing porch area outside room [ROOM NUMBER] was observed with a fabric chair with the fabric either peeled away, torn away or worn away; leaving a non cleanable surface. Photographic evidence was taken. Resident room [ROOM NUMBER]a was observed with a fall floor mat on the right side of the bed that had rips and tears and chunks torn away leaving a non cleanable surface. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident room [ROOM NUMBER]b was observed with a fall floor mat on the right side of the bed that had rips and tears and chunks torn away leaving a non cleanable surface. The C wing community shower room was observed with one of three plastic shower chairs with black and pink bio growth on the plastic joints of the lower legs. Photographic evidence was taken. Resident room [ROOM NUMBER] bathroom was dimly lit and not emitting bright light. It was revealed the light bulb needed changing. Resident room [ROOM NUMBER] was observed with a ceiling vent upon entering the room. There was a loud metal clicking that was constant and with a very loud noise during all days observed. Resident room [ROOM NUMBER]a was observed with a fall floor mat on the right and left side of the bed and had gouges, rips and tears and with surface separation, and leaving a non cleanable surface. The bathroom shower stall was observed with bio growth on the floor and wall tiles/grout lines. Resident room [ROOM NUMBER] shower room stall was observed with yellow and black bio growth on the floor tiles and grout lines. Photographic evidence was taken. The B wing community shower room was observed with one of three plastic shower chairs with pink, black and yellow bio growth on all four of the plastic legs. Photographic evidence was taken. The B wing “cubby” area between resident rooms [ROOM NUMBERS] was observed with two chairs blocked by unused wheelchairs and mechanical lifts. The B wing is a secured memory unit that has residents who are cognitively impaired and who walk through the hallways unassisted. Photographic evidence was taken. Resident room [ROOM NUMBER]b was observed with a fall floor mat on the right side of the bed that was torn and ripped, leaving a non cleanable surface. Resident room [ROOM NUMBER]a was observed with a fall floor mat on the right side of the bed that was torn and ripped, leaving a non cleanable surface. On 8/25/2025 at 10:30 a.m. an interview with the 200 memory unit Manager revealed all direct care staff and even housekeeping are responsible for observing resident rooms and spaces on a daily basis for cleanliness, maintenance and safety. She revealed all staff are to report broken items, soiled areas, unsafe equipment to the floor nurse, report it to the Maintenance department though electronic work order system and also report to her as the Unit Manager. She was able to confirm all the above areas noted and was not aware of those concerns. She did not know why staff when in resident rooms would not have identified the concerns. The Unit Manager did stated she believed Housekeeping staff were responsible for the cleaning and maintenance of resident wheelchairs. She was not sure if Housekeeping or other departments were responsible for upkeep and changing of broken and or cracked/torn armrests. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/2025 at 10:13 a.m. an interview with the facility’s Maintenance Director revealed he has four maintenance staff that work full time at the facility and the building is very large in nature with two stories and four units. The Maintenance Director revealed if there are any issues with the resident rooms, equipment and general upkeep of the building, staff are educated to submit a work order through the electronic work order system. He revealed the work orders are then addressed by priority and most work orders can be fixed and completed right away. He revealed he and his maintenance staff will try to round the building through the day but he nor his maintenance staff do daily room checks. He revealed there are many rooms and the direct care staff and nursing staff, as well as housekeeping staff should report work orders when they find things wrong. The Maintenance Director revealed he and his department are responsible for the general maintenance of resident wheelchairs to include changing of armrests, responsible for over the bed tables and will replace as need, and Central Supply department is responsible for the maintenance of fall floor mats. The Maintenance Director revealed he has not received any work orders from staff, nor has he or his maintenance staff seen any wheelchairs that need maintenance or fall floor mats that need replacing. The Maintenance Director confirmed observations of wheelchair armrests that needed to be changed due to rips and tears per observations on 8/28/2025. He did not have any type of maintenance logs related to wheelchair maintenance. 2. On 8/25/25 at 10:20 a.m., an interview with the residents in room [ROOM NUMBER] revealed the air conditioning (a/c) is loud. Resident #172 said he would rather have the portable fan on and the a/c off because it’s very loud and disrupts his sleep. He said he has told staff about it but does not think anything had been done. An oscillating pedestal fan was observed in the room, and it was on. An observation of the ceiling, by the door where the a/c unit and filter are, revealed a large crack and bubbled paint. On 8/25/25 at 11:41 a.m., an observation of the hallway between rooms [ROOM NUMBERS] revealed droplets of water were spattering on the floor forming a small puddle. Observations of the ceiling tiles revealed water marks and stains. A review of open, completed and cancelled work orders in the last two months revealed the following: - “quad [four rooms] work orders 133/134 water leaking from ceiling/ slip & [and] fall risk. … open date 8/6/25 closed date 8/6/25 …” - “134 – ceiling leaking in corridor A wing … open date 8/20/25 closed date 8/20/25 …” - “water leaking from ceiling quad rooms [ROOM NUMBERS] … open date 8/23/25 closed date 8/25/25 …” - no documentation regarding the a/c unit in room [ROOM NUMBER]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/25 at 9:52 a.m., an interview was conducted with the Director of Maintenance (DOM). A review of closed work orders regarding the room [ROOM NUMBER] and 134 corridor was conducted with the DOM. He said the pan under the a/c unit is not draining properly. The DOM said he was not sure what was completed for the work order, but thinks the pan was vacuumed. He stated, “During the hot months, it [the a/c] runs excessively, the pan fills up, and it leaks over into the ceiling tiles.” The DOM stated a long-term solution to fix the issue could be, “We can get up there and jet the line to fix it.” The DOM confirmed each room has their own a/c unit. He said the residents can turn it on or off. He said the residents have control of the fan in the a/c unit. The DOM said if the a/c is loud, it could be an issue with the unit, but he would have to look at it. The DOM was not aware there was a concern with the a/c being loud in room [ROOM NUMBER]. 3. An observation was conducted on 8/25/25 at 4:44 p.m. in room [ROOM NUMBER]. The privacy curtain between the beds had a brownish red substance splattered in multiple places on the curtain. An observation was conducted on 8/26/25 at 10:27 a.m. in room [ROOM NUMBER]. The privacy curtain by bed A had a brown substance stuck on the curtain in multiple locations. 4. During the course of the survey on 08/25/2025 to 08/27/2025 at varying times, the following was observed: - room [ROOM NUMBER], and 409 observed the raised toilet seat mechanically attached to the bowl. The mechanical attachments had brown oxidation and the raised toilet seat extension had a brown substance on surrounding the base of seat. - room [ROOM NUMBER]B – wall paint was pealing around the call light function box directly above the resident’s head. - room [ROOM NUMBER] bathroom floor was stained with a brown at the base of the toilet and surrounding the cove base. - room [ROOM NUMBER]A – assist rail had brown substance - room [ROOM NUMBER] bathroom observed the cabinet door leaning on the faucet not in the cabinet. - room [ROOM NUMBER] bathroom observed the toilet seat to be discolored and pealing, the show floor tiles had a brown stains below the faucet and surrounding the base tiles. - Soiled Utility room door near room [ROOM NUMBER] would not close. - room [ROOM NUMBER] shower chair seat was stained with brown, orange and yellow colors; under the sink was a build up of a black/brown substance, the wall under the sink had a brown substance in multiple locations; below the light switch, next to the soap dispenser was a section of wall not painted with brown area pealing and small holes. Review of the facility’s policy and procedure titled Cleaning and Disinfecting Residents’ Rooms, dated August 2013, revealed the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Purpose: The purpose of this procedure is to provide guidelines for cleaning and disinfecting residents' rooms. General Guidelines: 1. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 2. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. 4. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled. … Review of the facility’s policy and procedure titled Departmental (Maintenance) – Plumbing, HVAC and Related Systems, dated June 2011, revealed the following: Purpose: The purpose of this procedure is to guide the sanitary handling of the plumbing, heating, ventilation, air conditioning, and related systems within the facility. … General Guidelines: … 11. Inspect air-conditioning unit drains and filters weekly. Change filters at least monthly during use. Discard soiled filters. 12. Air-conditioning units should have major cleaning and maintenance performed in the spring and fall before the system is changed over. During the summer months check the unit daily for proper drainage of condensate. Promptly investigate reports of condensation appearing where it doesn't belong. 13. Clean or discard filters in individual air-conditioning units in the resident rooms at least monthly during the summer. Vacuum and maintain units as necessary. 14. Clean air vents and air handling units at least annually. Maintain exhaust fans at least every six (6) months. …

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 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: 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. 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. 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: … 3oz[ounce]/2c[cup] Chef Salad (Mo, We, Fr) [Monday, Wednesday, Friday] …” 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. 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. 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. A review of Resident #171’s quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. A review of Resident #171’s orders included the following: - “dietary consult to discuss food preferences as needed for pt [patient] request dietary consult, ” with an order date of 5/21/25. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #171’s progress notes and forms/assessments, after 5/21/25, revealed no documentation of a nutrition or dietary consultation regarding the resident’s food preferences. A review of grievances for Resident #171 revealed documentation of a grievance filed on 6/5/25 for, “Dining experience,” which was about temperature and the resident not liking the food. A review of Resident #172’s admission record revealed an admission date of 6/7/24 with diagnoses to include atherosclerotic heart disease of native coronary artery without angina pectoris, morbid (severe) obesity due to excess calories, diverticulitis of intestine, part unspecified, without perforation or abscess without bleeding, and hyperlipidemia. A review of Resident #172’s comprehensive MDS, dated [DATE], revealed a BIMS score of 15, cognitively intact. A review of resident council minutes from 3/2025 to 8/2025 revealed no documentation of concerns related to food choices, meal ticket accuracy, and/or honoring meal preferences/dislikes. A second review of grievances revealed from 3/2025 to 8/2025 there were no documented grievances from the food committee meetings and one documented on 3/3/25 from a resident council meeting about ice cream. On 8/25/25 at 2:15 p.m., an interview was conducted with the Nursing Home Administrator (NHA). She said the facility only had 2025 grievances, starting in January. She said the facility was not keeping a log of grievances prior to 2025. She said with the new team, including herself, they are documenting grievances. On 8/26/25 at 5:17 p.m., an interview was conducted with the Certified Dietary Manager (CDM). He said he only had three months of food committee minutes. He said he gave them to the previous administrator and does not know if the facility has record of them. A review of food committee minutes revealed the following: - 3/4/25, “… 7) We are still getting tickets wrong. Need to make sure that we check them better …” - 4/1/25, “… 7) We are still getting tickets wrong. Need to make sure that we check them better …” - 6/10/25, “ … 1) Reviewed the minutes from April 1th [first] Meeting. The residents talked about the issues that still are happening … 7) We are still getting tickets wrong. Need to make sure that we check them better. Did inservice with tickets again … “ - 7/1/25, “… 1) Reviewed the minutes from June 10th Meeting. The residents talked about the issues that still are happening. … 7) We are still getting tickets wrong. Need to make sure that we check them better. Did inservice with tickets again …” (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 8/5/25, “… 7) We are still getting tickets wrong. Need to make sure that we check them better. Did inservice with tickets again. … ” 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’s requests of food choices. He said he takes into consideration the residents and food committee’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 entrée, 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, “If he gets the message.” 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, “I need to get better at documenting. ” 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. 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’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’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’s concerns will be documented. The NHA confirmed those grievances were not documented previously. 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. 3. An interview was conducted on 8/28/2025 at 9:30 a.m. with Resident #8’s Healthcare Surrogate (HCS). The HCS stated she/he sent an email with three separate issues to the Social Service Coordinator, (SSC) on 6/13/2025 and has not been followed up with. A review of the grievance log revealed a grievance for 6/13/2025 which indicated an air-conditioning problem and was marked as resolved. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 8/28/2025 at 2:13 p.m. with the SSC. The SSC verified receipt of the grievance sent by Resident #8’s HCS on 6/13/2025 which included multiple issues. SSC stated she/he did not write the grievance for the nursing section but would try to find it. SSC stated Resident #8’s grievances are valid. No grievance was provided. 4. An interview was conducted on 8/25/25 at 11:02 a.m. with Resident #169 who stated he was not supposed to have tomatoes because of a significant history or ulcers. Resident #169 said he had talked to multiple staff members about concerns with food. The grievance log was reviewed and no grievances were found related to Resident #169’s dietary concerns. Review of admission Records showed Resident #169 was admitted on [DATE] with diagnoses including heart failure, myasthenia gravis, presence of a cardiac pacemaker, and dependence on supplemental oxygen. Review of Resident #169 admission Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, showed a brief Interview for mental (BIMS) score of 15, indicating she was cognitively intact. An observation was conducted on 8/25/25 at 12:21 p.m. of Resident #169’s lunch. The resident was observed to have stewed tomatoes on her lunch tray. 5. During an interview on 8/25/2025 at 9:05 a.m. Resident #213’s resident representative (RR) stated having several concerns with the facility with no resolutions and problems just continue and now Resident #213 has died. Review of the grievance logs for Resident #213 revealed: - On 3/26/25 for staff not checking the diet slip. Bugs/ants in room. Lack of follow up on prior grievances. Dishwasher broken and Styrofoam being utilized for too long. Floor not being cleaned. Corrective actions: dietary/Certified Nursing Assistant (CNA) educated on reading diet slips. No bugs were seen in the room. Confirmed many grievances were not follow up on. Dietary Manager will provide a divided plate instead of Styrofoam. Confirmed floor was dirty. Housekeeping to clean floor. Completion dated 4/2/25. - On 4/2/25 grievance revealed staff member who continues to be scheduled with resident after verbal altercation. Confirmed staff member still assigned to Resident #213. Corrective action: CNA schedule changed. - On 4/9/2025 missing hearing aids. Education to staff on storage of hearing aids. Completed 4/10/25. - On 4/24/25 grievance revealed diet slips not being followed. Confirmed and education to the staff completed on 4/30/25. (continued on next page)

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	105688	A. Building B. Wing	08/28/2025

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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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 6/1/25 grievance revealed: old water cup in room. Confirmed. Educated staff on hydration policy. Completed 6/6/25. - 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. - 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. - No other grievance were found or provided before for Resident #213. 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. Review of the Resident Council (RC) meeting minutes revealed: -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. -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. -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. -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. -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. -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; Review of the Grievance Logs revealed: - 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. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 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. 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. 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. 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. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure Preadmission Screening and Resident Review (PASRR) assessments were accurate and failed to submit a Level II PASRR for one resident (#8) out of three residents sampled.Findings included:Review of Resident #8's admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses to include mood disorder, insomnia, dementia and bipolar disorder.Review of the Level I PASRR, dated 7/04/2024, showed in Section II: Other Indications for PASRR Screen Decision-Making, questions 1 through 7 were marked No. A level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease), and a suspicion or diagnosis of a Serious Mental Illness. Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required was marked.An interview was conducted on 8/28/25 at 4:27 p.m. with the Assistant Director of Nursing (ADON). The ADON said the facility had started a PASRR audit. The ADON stated they have been going through each PASRR to see what is missing or a new diagnosis added. The ADON said outside of audits she has not done anything with existing residents. The ADON said a resident with schizoaffective disorder, schizophrenia, or post-traumatic stress disorder (PTSD) would need a level II submission. For Resident #8, the ADON said she just updated the PASRR level I but did not submit for level II. The ADON said she would submit a level II for Resident #8 for psychosis, but not for bipolar, dementia, or insomnia.A policy for PASRR was requested. The facility does not have a PASRR policy.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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: 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. 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. A review of Resident #213’s care plan record revealed: · 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. · Interventions revealed: o 11/6/23 initiated the following: § Anticipate residents’ needs. § Encourage and assist resident to toilet before and after meals and at bedtime. Offer urinal as indicated. § I should have sneakers, shoes, slippers with rubber soles or nonslip socks when I am out of bed. § 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). § Keep my call light within reach so I can call for assistance. § Offer/assist with nonskid socks as resident allows. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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: § encourage use of footrest while in wheelchair § 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: § bolsters on while in bed, scoop mattress § 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 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	o 5/26/25 initiated the following: § encourage and assist resident to common areas when out of bed. (repeat intervention) § Therapy eval (evaluation) for balance testing r/t Parkinson’s diagnosis. Resolved: 6/30/25 o 6/30/25 initiated the following: offer and assist to bed after visits from family. (repeat intervention) Review of the progress notes revealed: · 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. · 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. · 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. · 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 – High Risk, neuro checks started. Care plan updated 4/3/25 to review the wheelchair for function. · 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). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	· 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. · 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) · 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. · 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. · 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. · 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. · 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. · 7/6/25 at 3:55 p.m. progress note revealed: Resident left via ambulance to hospital. · 7/9/25 at 7:07 p.m. progress note revealed: Resident returned to facility from hospital via stretcher. Review of hospital records revealed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-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. -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. 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 residents’ chart indicating this has been completed, especially if the care plan does not have any changes needed. 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. 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. 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. 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. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	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. A review of Resident #81’s medical record from 1/1/25 to 2/16/25 did not reveal any incidents. 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. 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. 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. 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. … Assessment and Plan: Peripheral edema: Ultrasound of left leg to rule out DVT (deep vein thrombosis)… Orders for this Visit: Ultrasound of left leg 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. … Assessment and Plan: Peripheral edema: US (ultra sound) results unremarkable Will monitor … (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. 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). A review of Resident #81’s provider note dated 3/7/25 revealed: … 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. … Assessment and Plan: Peripheral edema: Ok per POA to have x-ray of left knee. 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. Review of the hospital emergency room physician report dated 3/8/25 revealed: eyes open and grimaces in pain only, … Left upper extremity: … limited range of motion (ROM) left shoulder, elbow, wrist, and hand; with no crepitation or deformity noted some contractures …, Right Upper Extremity: … limited ROM right shoulder, elbow, wrist and hand; with no crepitation or deformity noted some contractures, … Left Lower Extremity: … contracture of the knee bruising about the left thigh l; … right lower extremity: … limited ROM right hip, knee, ankle and foot; … 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. 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. … 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. … 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. … (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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. 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. 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, “odd if you were to ask me”. Staff TT, CNA states not knowing anything about what happened. 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. 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. 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. … 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. … 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. … 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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to 1) provide adequate catheter care for Resident # 10, and 2) ensure documentation of catheter care was completed for Resident #125, out of three residents sampled for catheter care.Findings Included: 1) During an interview with Resident #10 on 08/25/2025 at 9:45a.m., the resident voiced concerns regarding lack of care for her suprapubic catheter. The resident stated no one had cleaned the site or changed the dressing on her catheter for three days. Resident #10 voiced a concern of her catheter care not being done correctly since a nurse who previously did most of her care resigned from the facility. A follow-up interview was conducted on 08/26/2025 at 10:20 a.m. where the resident stated she had still not received care for her catheter. Resident #10 stated she did ask a nurse if the catheter was going to be replaced as previously it had been replaced every 30 days, but the nurse told her there was no order for that. Resident #10 was admitted to the facility on [DATE] with a primary diagnosis of Paraplegia, unspecified, Pressure Ulcer Of Left Buttock, stage 4, Schizoaffective Disorder, Bipolar Type, Neuromuscular Dysfunction Of Bladder, Unspecified, Chronic Kidney Disease, stage 3 unspecified. Review of resident’s quarterly Minimum Data Set (MDS) dated [DATE] revealed resident’s Brief Interview for Mental Status (BIMS) revealed a score of 15 out of 15 indicating no cognitive impairments. Section GG indicated impaired range of motion for her lower extremities and that resident was dependent for all care areas. Section H indicated resident had an indwelling catheter and was frequently incontinent of bowels. Section I indicated resident had anemia, renal insufficiency, neurogenic bladder, diabetes mellitus, paraplegia. A review of Resident#10’s Care Plan dated 06/13/2025 revealed the following: A focus of resident needing assistance with activities of daily living because of weakness/Paraplegia, altered skin integrity, mood disorders with goals of staff helping the resident all of her ADL (activities of daily living) needs so that she appeared neat and tidy with absence of foul body odor through next review and interventions of staff assisting resident with toileting needs promptly when asked and bilateral siderails/enablers for bed mobility. A focus of resident having incontinence of bowel, indwelling catheter r/t Neuromuscular Dysfunction Of Bladder with goals to monitor indwelling catheter through next review, manage UTIs (urinary tract infections) with early detection and treatment through next review with interventions of staff to irrigate catheter as per orders, monitor for incontinence frequently and provide prompt care, and monitor for urinary retention and signs/symptoms of UTI, Obtain and monitor lab/diagnostic work as ordered. Report results to MD (medical doctor) and follow up as indicated, Provide catheter care every shift and as needed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Staff CC, Licensed Practical Nurse (LPN) on 08/27/2025 at 12:18 p.m., the LPN stated resident #10 was supposed to have her suprapubic catheter site cleaned and the dressing changed during the night shift, but upon irrigating the resident’s suprapubic catheter the LPN noticed it had not been cleaned and the dressing had not been changed on the previous shift. During an interview with Staff Z, Certified Nursing Assistant (CNA) on 08/27/2025 at 10:01AM. The CNA stated Resident #10 got her suprapubic catheter changed and taken care of by the nurses and the CNAs were only responsible for emptying the catheter bag. The CNA stated CNAs were not responsible for looking at or cleaning the suprapubic catheter site as part of their job duties. 2. An interview was conducted on 8/27/25 at 3:15 p.m. with Resident #125. She stated her catheter care is done but not necessarily every shift like it supposed to be. Review of admission Records showed Resident #125 was admitted on [DATE] with diagnoses including pulmonary embolism and ventral hernia. Review of Resident #125 BIMS, dated 7/29/25, showed a score of 13 indicating she is cognitively intact. Review of Resident #125’s order listing showed an order for “Indwelling Urinary Catheter care every shift with soap and water,” dated 8/20/25. Review of Resident #125’s August 2025 Treatment Administration Record (TAR) showed catheter care was not signed off as completed on 8/5/25 evening shift, 8/7/25 day shift, 8/17/25 evening shift, and 8/18/25 night shift. Review of Resident #125’s lab results revealed a urinalysis collected on 8/19/25 indicating the resident had a urinary tract infection (UTI). Review of Resident #125’s orders showed an order, dated 8/22/25, for Ciprofloxacin HCL 500 mg. 1 tablet by mouth twice a day for a UTI for 7 days. A review of the facility policy titled Catheter Care, Urinary, revised August 2022, revealed the following: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PurposeThe purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tractinfections.Preparation1. Review the resident's care plan to assess for any special needs of the resident.2. Assemble the equipment and supplies as needed.General Guidelines1. Follow aseptic technique when inserting a urinary catheter.2. Maintain a closed drainage system when possible.3. Empty the collection bag at least every eight (8) hours using a separate, clean collection container foreach resident. Avoid splashing, and prevent contact of the drainage spigot with the nonsterile container.4. Ensure that the catheter remains secured with a securement device to reduce friction and movement atthe insertion site. Catheter Evaluation1. Review and document the clinical indications for catheter use prior to inserting.2. Nursing and the interdisciplinary team should assess and document the ongoing need for a catheter thatis in place. Use a standardized tool for documenting clinical indications for catheter use.3. Remove the catheter as soon as it is no longer needed.Perineal Care1. Use soap and water or bathing wipes for routine daily hygiene. Antiseptic wipes for daily cleansing arenot recommended.2. Clean the area under the foreskin in uncircumcised males daily.Infection Control1. Use aseptic technique when handling or manipulating the drainage system.2. Be sure the catheter tubing and drainage bag are kept off the floor.Input/Output1. Observe the resident's urine level for noticeable increases or decreases. If the level stays the same, orincreases rapidly, report it to the physician or supervisor.2. Follow the facility procedure for measuring and documenting input and output.Maintaining Unobstructed Urine Flow1. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheterand tubing free of kinks.2. Unless specifically ordered, do not apply a clamp to the catheter.3. Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into theurinary bladder. 4. If the catheter material contributes to obstruction, notify the physician and change the catheter if instructed to do so.5. Catheter irrigation may be ordered to prevent obstruction in residents at risk for obstruction. Changing Catheters1. Do not change indwelling catheters or drainage bags at routine, fixed intervals.2. Change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised.3. Residents who form encrustations that can quickly lead to an obstruction need more frequent catheter changes (i.e., weekly or twice weekly) at intervals specific to the individual resident. The catheter should be changed before blockage is likely to occur.4. When changing a long-term indwelling catheter, leave the catheter out for at least 1 hour, but no longer than 2 hours, to allow the urethral glands to drain . DocumentationThe following information should be recorded in the resident's medical record:1. The date and time that catheter care was given.2. The name and title of the individual(s) giving the catheter care.3. All assessment data obtained when giving catheter care.4. Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor.5. Any problems noted at the catheter-urethral junction during perinea! care such as drainage, redness, bleeding, irritation, crusting, or pain.6. Any problems or complaints made by the resident related to the procedure.7. How the resident tolerated the procedure.8. If the resident refused the procedure, the reason(s) why and the intervention taken. 9. The signature and title of the person recording the data.

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	08/28/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure oxygen was administered per physician orders for four residents (#179, #117, #65, and #6) out of six reviewed for oxygen therapy. Findings included: 1. An observation and interview was conducted on 8/25/25 at 10:47 a.m. of Resident #117. Resident #117 was in bed resting with a nasal cannula (n/c) in place. The oxygen (O2) concentrator was observed to be running at 4 liters/minute (L/min). The resident said she does not mess with the oxygen; the nurse does that. Review of admission Records showed Resident #117 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD) and dependence on supplemental oxygen. Review of Resident #117 Brief Interview for Mental Status (BIMS), dated 8/6/25, showed a score of 15 indicating she was cognitively intact. Review of Resident #117’s Care Plan showed a focus area of oxygen therapy as needed related to ineffective gas exchange, dated 8/25/25. Interventions included O2 settings via n/c per order. Review of Resident #117’s physician orders showed: -O2 at 2 L/minute (min) via n/c to keep O2 equal or more than 92% as needed for hypoxia, dated 8/23/25. -O2 at 3L/min per n/c as needed (PRN) to maintain pulse ox >92%, dated 8/18/25 and discontinued 8/27/25. -O2 at 2L/min via n/c continuously, dated 7/24/25 and discontinued 7/25/25. Review of Resident #117’s August 2025 Treatment Administration Record (TAR) showed PRN oxygen administration had not been signed off as being administered from 8/18-8/28/25. Another observation was conducted on 8/27/25 at 2:25 p.m. of Resident #117 in his room lying in bed with nasal cannula in place and the oxygen concentrator running at 2 3/4 L/min. On 8/27/25 at 3:28 p.m. the resident was sleeping in bed with the nasal cannula in place and the oxygen concentrator remained running at 2 3/4 L/min. An interview was conducted on 8/28/25 at 2:17 p.m. with the Director of Nursing. She reviewed pictures of Resident #117’s oxygen concentrator and confirmed each of the three observations the concentrator was not running at the ordered 2 L/min. When asked if the nurses knew how to properly read the oxygen concentrator flowmeter she shrugged her shoulders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. An observation was conducted on 8/25/2025 at 9:30 a.m. of Resident #179. The resident was observed sitting in a wheelchair next to the bed wearing oxygen via a nasal cannula (n/c) set at 2.5 liters (L) on the oxygen (O2) concentrator. A second observation and interview with Resident #179 was conducted on 8/27/2025 at 2:20 p.m. The resident stated she/he is on 2.5 L/min of oxygen. The resident’s O2 concentrator was observed to be set at 2.5 L/min. A review of the resident’s admission record revealed she/he was admitted to the facility on [DATE] with diagnoses to include pulmonary fibrosis, atrial fibrillation, and hypertension. A review of Resident #179’s active orders revealed the following order: - “Oxygen - May remove oxygen for transports and showers; No directions specified for order.” A review of Resident #179’s active care plan revealed the following: -Focus: “I have impaired respiratory status…” with an intervention of: “Oxygen 2. 5L/min {minute} via nasal cannula continuously.” -Focus “I need assistance with activities of daily living…” with an intervention of: “oxygen 4L/min via nasal cannula continuously.” -Focus: “The resident has oxygen therapy…” with an intervention of: “oxygen settings 2L/min via nasal cannula.” An interview was conducted on 8/27/2025 at 2:25 p.m. with Staff LL, Licensed Practical Nurse (LPN). The staff member stated she/he thinks Resident #179 is on 2L of oxygen. Upon checking the order, Staff LL was unable to locate the oxygen parameters. An interview was conducted on 8/27/2025 at 2:39 p.m. with Staff A, Unit Manager (UM) and Staff LL. Staff A stated Resident #179 should be on 2-2.5L of oxygen. Staff A stated the order was not in the system correctly. An order was put in after this interview. The order revealed the following: -“Oxygen at 2L via NC continuous -May remove oxygen for transports and showers No directions specified for order. Other-Active 8/27/2025” 3. An observation was made on 08/27/2025 at 9:05AM. Resident #6 was on 3L of oxygen (picture provided) connected to a tracheostomy tube (trach) through a humidifier machine. A review of the resident's physician's orders showed no order regarding how many liters of oxygen, order showed 28% humidified oxygen through trach. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview was conducted with Staff X, Licensed Practical Nurse (LPN) on 08/28/2025 at 9:18a.m. She voiced she was not sure how many liters of oxygen resident #6 was supposed to be on but she knew she had humidified oxygen through her trach. She then looked on her computer to find the orders and was unable to locate them. LPN walked into the residents room and confirmed the oxygen was at 3 liters, however she could not find it in the resident's orders. LPN agreed it would be difficult to know if the resident was on the right amount of oxygen without being able to see the order. She stated she would need to ask the RN manager as she could not find it anywhere. Interview with Staff Y, Registered Nurse (RN) manager was conducted on 08/28/2025 at 9:22a.m., RN stated Respiratory Care handles all of the tracheostomy care for the resident and she would have to reach out to them to find out how many liters it was supposed to be on. Stated someone from Respiratory Care came once a week to handle all of the tubing, settings, etc. for resident's trach. On 08/28/2025 at 10:15a.m., Staff DD unit manager showed on the humidifier for the oxygen the label showing 28% humidified oxygen--2.5L. She confirmed the oxygen was set to 3L, and confirmed she felt that was the appropriate setting for the resident. A review of the medical record for Resident #6 revealed the resident was admitted to the facility on [DATE], with diagnoses of Unspecified Diastolic (Congestive) Heart Failure, Need For Assistance With Personal Care, Tracheostomy Status, 2 Diabetes Mellitus With Unspecified Complications, Muscle Weakness (Generalized), Cognitive Communication Deficit. A review of the MDS showed a BIMS score of 00 suggesting significant cognitive impairment. Section GG revealed resident was dependent in all applicable care areas. Section O shows resident was receiving oxygen therapy, tracheostomy care, IV medication, and IV access. A review of Resident #6 orders showed orders: [Respiratory Care] RT to change trach every 90 days, every day shift every 90 day(s) dated 07/29/2025 Trach- Change suction cannister and tubing, Trach- Change trach mask and tubing, Trach- Change trach ties- every day shift every Mon AND as needed for infection control-dated 07/28/2025 Trach- Continuous humidified oxygen 28% via trach mask. Monitor oxygen saturation-every shift-dated 03/26/2025 Trach- Maintain Ambu bag at bedside. Maintain replacement trach of equal size and one size smaller at bedside. If decannulation occurs, reinsert spare trach. If unable to reinsert, call 911-every shift-dated 03/26/2025 Trach- Trach care with sterile saline. Change inner cannula- Trach- Trach care with sterile saline. Change inner cannula-every night shift AND as needed for obstruction prevention/infection control-03/25/2025 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of resident #6s care plan revealed focus of “Resident has the potential for respiratory complications due to tracheostomy, respiratory failure with goal of Airway will remain patent and complications will not develop secondary to having a tracheostomy thru next review, and interventions Assess lung sounds, change inner cannula as per orders, Change trach ties, trach mask, suction cannister and tubing as per orders, Enhanced barrier precautions, HOB 45 degrees at all times• HUMIDIFIED TRACH COLLAR as per orders• Maintain Trach replacement size 6 shiley XLT at bedside as per orders • Monitor skin integrity under and around trach. Notify MD of any changes• Suction as ordered • Trach care as per orders. 4. An observation and interview was conducted on 8/25/25 at 11:29 a.m. of Resident #65. Resident #65 was sitting up, on the side of the bed, dressed and receiving oxygen from a concentrator via a nasal canula. The oxygen (O2) concentrator was observed to be running at 1.5 liters (L). The resident said he/she doesn’t mess with the oxygen; the nurse does that. Review of admission Records showed Resident #65 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD); acute respiratory failure with hypoxia; other disorders of lung; and other co-morbidities. Review of Resident #65’s Brief Interview for Mental Status (BIMS), dated 8/27/25, showed a score of 12/15 indicating moderate cognitive impairment, suggesting the individual has significant but not severe deficits in their cognitive abilities. Review of Resident #65’s Care Plan showed: - A focus area of oxygen therapy related to shortness of breath, dated 9/26/24. Interventions included O2 settings as per orders. - A focus The resident has altered respiratory status/difficulty breathing related to COPD, acute respiratory failure and other disorders of the lung dated 5/17/24. Interventions included oxygen as per order. Review of Resident #65’s physician orders showed: -O2 at 4 L/minute (min) via n/c to as needed to keep O2 below 92% as needed for low O2, dated 2/28/25 and discontinued 8/27/25. -Portable O2 therapy via n/c at 2L/min as needed (PRN) while patient is ambulating as needed for COPD, dated 6/11/25 and discontinued 8/27/25. Review of the facility’s policy and procedure titled Oxygen Administration with a revision date of October 2010 showed the following: (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Purpose The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Preparation 1. Review the resident's care plan to assess for any special circumstances or precautions related to the resident. 2. Assemble the equipment and supplies needed. General Guidelines 1. Distilled water used in respiratory therapy must be dated and initialed when opened, and discarded after twenty-four (24) hours. 2. Condensate in the breathing circuits must be drained back into waste bottles, which must be marked with the resident's name, and emptied into the toilet or hopper at the end of every shift. Condensate should be considered infectious. Condensate should never be drained back into the breathing circuit or cascade. 3. Transport respiratory therapy equipment to designated soiled utility area for decontamination. Equipment and Supplies The following equipment and supplies will be necessary when performing tasks related to this procedure: 1. Appropriate equipment/supplies necessary for ordered therapy; 2. Waterless antiseptic handwash (as indicated); and 3. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). Steps in the Procedure Infection Control Considerations Related to Oxygen Administration 1. Obtain equipment (i.e., oxygen tubing, reservoir, and distilled water). 2. Use distilled water for humidification per facility protocol. 3. [NAME] bottle with date and initials upon opening and discard after twenty-four (24) hours. 4. Check water levels of refillable humidifier units daily. If the water level falls below the fill line: a. Discard residual solution; b. Pour a small amount of distilled water into the reservoir and swish around to rinse all surfaces; c. Discard water; d. Refill with distilled water to fill line; and e. Change the reservoir every forty-eight (48) hours and disinfect with 2% alkaline glutaraldehyde or sterilize. 5. Check water level of any pre-filled reservoir every forty-eight (48) hours. 6. Change pre-filled humidifier when the water level becomes low. 7. Change the oxygen cannula and tubing every seven (7) days, or as needed. 8. Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use. 9. Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry. 10. Wash hands after manipulation. Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol: 1. Obtain equipment (i.e., administration set-up, plastic bag, gauze sponges). 2. Wash hands. 3. After completion of therapy: a. remove the nebulizer container; b. rinse the container with fresh tap water; and c. dry on a clean paper towel or gauze sponge. 4. Reconnect to the administration set-up when air dried. 5. Take care not to contaminate internal nebulizer tubes. 6. Wipe the mouthpiece with damp paper towel or gauze sponge. 7. Store the circuit in plastic bag, marked with date and resident's name, between uses. 8. Wash hands. 9. Discard the administration set-up every seven (7) days. Infection Control Considerations Related to Mechanical Ventilators: 1. Obtain appropriate equipment (i.e., breathing circuits (as indicated), sterile water, and waste water bottle). 2. Change the ventilator circuits and cascades every forty-eight (48) hours. 3. Do not disconnect the cascades from the heat supply, even when not in use. 4. Change the cascade reservoir and disinfect using 2% alkaline glutaraldehyde or sterilize it. 5. Fill the cascade with sterile distilled water. 6. When cascades need refilling, discard residual fluid. Pour a small amount of sterile distilled water into the cascade. Swish around to rinse all surfaces. Discard the water and refill with sterile distilled water. 7. Drain condensate from corrugated tubing into waste bottles marked with the resident's name. Empty bottles into toilet or hopper at the end of the shift, and as necessary. (Note: Never allow condensate to drain back toward resident or into cascade.) 8. When disconnecting tracheostomies from the breathing circuit, direct the mist away from the resident and your face. 9. Check filters once weekly while they are in continuous use. Discard filters or sterilize them between uses for different residents. 10. Clean and disinfect the surface of the ventilator as necessary and between uses for different residents. Documentation The following information should be recorded in the resident's medical record: 1. The date and time the respiratory therapy was performed. 2. The type of respiratory therapy performed. 3. The name and title of the individual(s) who performed the respiratory therapy. 4. All assessment data obtained during the treatment. 5. If the resident refused the therapy, the reason(s) why and what was done as a result. 6. The signature and title of the person recording the information.

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

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide effective pain management in a timely manner for one resident (#179) out of one resident sampled for pain management. Findings included:An interview was conducted on 8/25/2025 at 9:30 a.m. with Resident #179. The resident stated she/he was not receiving adequate pain medication and had to wait for hospice. The resident was observed in a wheelchair, dressed in appropriate clothes. The resident stated she/he has a lot of back pain. The resident stated staff can't give anything else, she/he is waiting for hospice. The resident appeared to be wincing in pain.An observation and interview were conducted on 8/27/2025 at 10:41 a.m. The resident was observed in a wheelchair next to the bed, dressed in appropriate clothes. The resident is still reporting a lot of pain in the back. The resident stated she/he wakes up and gets into the wheelchair and doesn't go back to bed because she/he is in so much pain. The resident was observed wincing in pain pointing to the same area of the back. The resident stated hospice was there yesterday 8/26/2025, they prescribed something different for the pain but was told by staff they don't have it from pharmacy yet.Review of Resident #179's admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses to include: pulmonary fibrosis, diabetes, atrial fibrillation, hyperlipidemia, hypertension, and end stage renal disease. Review of Resident #179's Order Summary revealed the following order:- Baclofen Oral Tablet 10 MG {milligram} (Baclofen)Give 1 tablet by mouth every 8 hours as needed for Muscle spasm Hospice orderPharmacy-Active 8/26/2025 13:15Review of the August 2025 Medication Administration Record (MAR) revealed the following pain levels:8/25/2025-1:11 a.m. pain level 2/10; 1:07 p.m. pain level 9/10;8/26/2025-4:37 a.m. pain level 6/10; 10:28 a.m. pain level 9/10; 8/27/2025- 5:20 a.m. pain level 7/10; 11:25 a.m. pain level 5/10; 7:07 p.m. pain level 5/10Further review of the MAR revealed the Baclofen oral tablet 10 MG was not documented as administered until 8/28/2025 at 3:48 a.m.Review of Resident #179's active Care Plans revealed the following:-Focus: I have a risk for discomfort/pain due to decrease in mobility, end of life care-hospice r/t interstitial lung disease. with interventions to include: - Administer analgesic as per orders; - Evaluate the effectiveness of pain interventions, alleviation of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition; - Instruct and reinforce to resident regarding what pain medications are available to him/her, dose and frequency; - Notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain -Focus: {Resident} have elected to have end of life care due to {resident} is receiving Hospice services due to terminal prognosis, decline is anticipated and unavoidable in all areas as disease process progresses r/t interstitial lung disease. With an intervention of: Observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain.An interview was conducted on 8/27/2025 at 10:43 a.m. with Staff LL Licensed Practical Nurse (LPN). Staff LL stated they can contact hospice if we need anything. The staff member was not sure where the medication Baclofen was, as it was not located on the medication cart and stated maybe it hasn't been delivered from pharmacy yet. Staff LL inquired with Staff A, Unit Manager (UM). Staff A stated they can pull the medication from the emergency drug kit (EDK).An interview was conducted on 8/27/2025 at 10:50 a.m. with Staff A, (UM). Staff A stated she/he contacted hospice on Monday 8/25/2025 and received a call back on Tuesday 8/26/2025. Hospice prescribed Baclofen 10MG on 8/26/2025. UM stated she/he is having a different UM to pull the medication since she/he doesn't have access to the EDK.An interview was conducted on 8/27/2025 at 2:44 p.m. with Staff CC, LPN. Staff CC was the primary nurse of Resident #179 on 8/26/2025. The staff member stated the resident complained of pain and the resident expressed she/he wanted the baclofen. Staff CC stated Staff A, UM put the order in, but the medication never came from the pharmacy.An interview was conducted on 8/28/2025 at 2:17 p.m. with the Director of Nursing (DON). Regarding pain medication, the DON stated once the order is in, if it is in the cart-they can get it or they can get it from the EDK. Regarding Resident #179, DON stated the resident should have gotten the baclofen when it was ordered. The DON agreed the staff could have called the medical director to get an order on Monday 8/25/2025 while waiting for hospice to return the call.A medication administration policy was requested but not provided.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **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: 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. Review of admission Records showed Resident #216 was admitted on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction. 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. 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. 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. 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. 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. 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. Review of Resident #52’s BIMS, dated 8/13/25, showed a score of 9, indicating moderately impaired cognition. 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. (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident Council (RC) meeting minutes revealed: - 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. 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. 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. 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. 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.” 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. 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. 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.” 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. (continued on next page)

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Aventura at the Bay	10300 4th St N Saint Petersburg, FL 33716

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure medications were stored and secured in accordance with guidelines related to 1) medications improperly labeled and stored in resident rooms (#316 and #416); 2) medications left out in an unlocked office; 3) glucose test strips undated in a medication cart; 4) personal items stored with medications; and 5) improper disposal of a medication observed during three of four days of survey. Findings included: An audit of the A-wing Mid medication cart was conducted on 8/28/2025 at 11:40 a.m. Narcotics were stored in a separate locked compartment; hearing aids and a hearing aid charger were observed stored in the drawer with the medications. Staff KK, Licensed Practical Nurse (LPN) stated those should not be in there. An observation was conducted on 8/25/25 at 11:39 p.m. of a prescription tube of Triamcinolone Cream 0.1 sitting on the bathroom counter of room [ROOM NUMBER]. An observation was conducted on 8/25/25 at 4:39 p.m. of a prescription tube of Ammonium Lactate 2% sitting on a bedside table in room [ROOM NUMBER]. There were also two medicine cups, each containing a white cream substance. One was labeled leg and the other labeled calf. An observation was conducted on 8/26/25 at 10:16 a.m. of an office on the C wing with the sign “Nurse Supervisor” on the door. The door was open to a resident hall with no staff present. Inside the office there was an unlocked treatment cart containing prescription medications as well as iodoform packing and wound cleanser sitting out. The same office was again observed to have the door open with no staff present on 8/27/25 at 3:26 p.m. The iodoform packing and wound cleanser remained sitting unlocked in the office. An observation was conducted on 8/26/25 at 4:55 p.m. of Staff R, LPN. Staff R was observed administering medication to a resident. The resident refused one of the pills. Staff R was observed removing the pill from the medication cup and throwing it in the trash can on the side of the medication cart. An audit was conducted of a D wing medication cart on 8/26/25 at 5:26 p.m. with Staff R, LPN. There was one loose medication capsule in the drawer and two bottles of glucose test strips that had been opened and not dated. The narcotic drawer contained a folded piece of paper with money inside being stored in the compartment with medication. Staff R said loose pills should be put in drug buster to dispose of them. Staff R confirmed she had thrown a medication in the trash can and stated it should not have been put there. Staff R also stated glucose tests strips should always be dated with the date they are opened, and he/she didn’t know why two bottles were open. Staff R said the test strips are only good for 6 months after being opened. Staff R said the folded paper with money belonged to a resident and was stored there to keep it safe. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An audit was conducted of a C wing medication cart on 8/28/25 at 10:23 a.m. with Staff S, RN. The cart contained a container of glucose test strips that had been opened but not dated. Staff S said the container should have the date the test strips were open written on it because they are only good for “like 90 days”. Staff S then proceeded to write 8/28/25 on the test strip container and admitted to not knowing when they were opened. An audit was conducted of a second D wing medication cart on 8/28/25 at 10:36 a.m. with Staff T, LPN. The top drawer of the cart contained a medication cup with three pills in it. The cup only had a resident name on it. Staff T said he/she had no idea what the medication was or when it was supposed to be given. Staff T said he/she had just received keys to the medication cart and the cup with pills was already in the top drawer. Staff T confirmed pills should not be left in the cart in a medication cup. The narcotic drawer contained a plastic bag with a cell phone and other personal items being stored in the same compartment as medication. Staff T said the bag had resident’s items and she didn’t know it couldn’t be in with the medications. An interview was conducted on 8/28/25 at 2:11 p.m. with the Director of Nursing (DON). The DON said prescription creams such as Ammonium Lactate should not be left out in a resident room. She reviewed pictures of the medication cups with cream in them and said she didn’t know what the cream was, and it should not be left in the resident room. The DON also confirmed breathing treatment medication should not be left at a resident’s bedside unless they have a self-administration order and then it should be locked in a drawer. The DON said glucose test strips should always be dated with the opening date and medication should be disposed of in “drug buster” not the trash can. The DON reviewed the pictures of the medication cup with pills that had been left in the medication cart. She said she did not know what the pills were and said they should never have been left like that. The DON agreed the resident might have missed their medication. The DON said often residents hearing aids or money are locked in the medication carts overnight or until a family picks the items up. She said for over 30 years she has been doing this job items were locked in the narcotic box with medications. The DON said she did not know who used the “Nursing Supervisor” office on the C wing, but it should be locked if there is medication in there. Review of a facility policy titled “Medication Labeling and Storage,” revised February 2023, showed: Policy Statement: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Policy Interpretation and Implementation Medication Storage 1. Medications and biologicals are stored in the packaging comma containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner… (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others…

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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 0806 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure food allergies and preferences were honored for four residents (#169, #71, #171, #172) out of six sampled for dietary concerns. Findings included: 1) An interview was conducted on 8/25/25 at 11:02 a.m. with Resident #169. Resident #169 stated he/she was allergic to fish and about a week ago he/she was served a fish sandwich. The resident said the tray card did not say what the meal was, and it did not look like fish. Resident #169 stated he/she took two bites of the sandwich before feeling his/her throat start to close. The resident said the nurse had to come and administer the epinephrine (epi) pen that is ordered for life threatening allergies. Resident #169 said a nurse practitioner (NP) also came in and provided care. The resident states he/she also was not supposed to have tomatoes because of a significant history of ulcers. Review of admission Records showed Resident #169 was admitted on [DATE] with diagnoses including heart failure, myasthenia gravis, presence of a cardiac pacemaker, and dependence on supplemental oxygen. Review of the facility’s Allergy Report, Resident #169’s food allergies were listed as crab, fish and seafood, peanuts, and shrimp. Review of Resident #169 admission Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, showed a brief Interview for mental (BIMS) score of 15, indicating she was cognitively intact. Review of Resident #169’s progress notes showed: 8/15/25 4:16 p.m. Nursing note by Staff EE, Registered Nurse (RN). “SN [Skilled Nurse] was informed by the CNA [Certified Nursing Assistant] that the patient was c/o [complaining of] having SOB [shortness of breath] due to eating some fish from lunch; informed the CNA that she hadn't ate fish in 20 years and that she had a allergy to fish & c/o having SOB. SN immediately went to assess to the patient. Once entering the pt room she was sitting in her chair at the bedside still alert and talking. She c/o having SOB. SN checked pt [patient] orders for Epi-Pen and gave injection - Epinephrine 0.3mg for anaphylaxis to left thigh; and applied 2L/min via NC [nasal cannula] PCP [primary care provider] & Family were notified. New order received by [NAME], APRN [Advanced Practice Registered Nurse] who also was present during the incident; to apply 02 @ 2L/min. Allergy list has been updated; SN also informed the patient to not eat anything in the future that she has a allergy to; per the son the pt stated that it didn't look like fish. Pt has been doing fine s/p [status post] bEpi injection. Staff will continue to monitor the pt.” Review of Resident #169’s physician orders showed: -Epinephrine Solution Auto-injector 0.3 mg/0.2 ml. Inject 1 application intramuscularly as needed for anaphylaxis until 9/9/25. Administration: press firmly against the outer thigh until you hear it click. Hold in the thigh for 10 seconds. Can be given through clothing. Dated 8/9/25. (continued on next page)

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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 0806 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #169’s August 2025 Medication Administration Record (MAR) showed epinephrine was administered 8/15/25 at 11:28 a.m. and it was documented as effective at 12:43 p.m. An interview was conducted on 8/26/25 at 3:36 p.m. with the Director of Nursing (DON). The DON said Resident #169 had not told the facility she was allergic to fish, and they did not know. She said the resident ate the entire fish sandwich and did not have a reaction. The DON said Resident #169 only complained of itching on her arms. She said the doctor was called and the epi pen was administered “to make her feel better.” The DON said Resident #169 did not have an anaphylactic reaction and did not have to go to the hospital. Review of Resident #169’s hospital records from 8/4-8/9/25, provided by the facility, listed allergies including crab, fish, lactose, peanuts, shrimp, and tomatoes. Review of Resident #169’s Primary Care Provide note, dated 8/11/25, listed allergies included crab, fish flavor, lactose, peanut, shrimp, and tomatoes. The Primary Care Provider note, dated 8/18/25 noted Resident #169’s “only concern is that of [his/her] meal preference and allergies not being addressed by Dietary.” An observation was conducted on 8/25/25 at 12:21 p.m. of Resident #169’s lunch. The resident was observed to have stewed tomatoes on her lunch tray. An interview was conducted on 8/28/25 at 10:16 a.m. with Staff EE, RN. Staff EE said he/she was assigned Resident #169 on 8/15/25 when she had an allergic reaction. Staff EE said a CNA came down and said it appeared Resident #169 was short of breath. The nurse said the resident was having a hard time taking a good deep breath but did not have any other symptoms. Staff EE said she went to the resident’s room and the NP that was on the unit went with as well. Staff EE said the epi pen was administered to the resident quickly and the resident had relief. Staff EE said allergies are listed on the resident’s tray cards and the assumption was that the kitchen checked to make sure the residents were not served food they were allergic to. Staff EE said he/she was not aware of a process in place to check the tray for allergies on the unit. An interview was conducted on 8/28/25 at 1:57 p.m. with Staff FF, NP. Staff FF confirmed he/she was on the unit when a CNA said Resident #169 was having an allergic reaction. Staff FF said the nurse told her there was an emergency. The CNA said Resident #169 had eaten fish and was allergic to it. Staff FF said he/she entered the room with the nurse. Staff FF said the resident was having a difficult time breathing and said he/she felt like their throat was closing. Staff FF said the nurse administered the epi pen and had a second epi pen available if the resident needed it. Staff FF said the nurse was told to administer the second epi pen if the resident had any further breathing issues. 2) An observation was conducted on 8/25/25 at 4:47 p.m. of Resident #71’s dinner. The resident was observed sitting on the side of the bed. The dinner tray had been delivered to his/her room. Resident #71 was observed opening the container and inside was a whole beef steak with rice and round carrots. The tray card on the resident’s tray had “Alerts: CUT MEAT IN BITE SIZE PIECES” The resident complained the food was cold, a nurse came to the room and took the tray to heat it up, then returned the tray to the resident with the beef steak still whole. (continued on next page)

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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 0806 Level of Harm - Actual harm Residents Affected - Few	Review of admission Records showed Resident #71 was admitted on [DATE] with diagnoses including intraarticular fracture of lower end of left radius, nondisplaced fracture of left ulna styloid process, dysphagia, gastro-esophageal reflux disease (GERD) without esophagitis, mild cognitive impairment, and cognitive communication deficit. Review of Resident #71’s 7/3/25 admission MDS, Section C, Cognitive Patterns, showed a BIMS score of 15 indicating he/she was cognitively intact. Section GG, Functional Abilities, showed the resident needed partial/moderate assistance for eating. Review of Resident #71’s care plan showed a focus area of risk for alteration in nutritional status related to left radius fracture, diabetes mellitus type 2, hypertension, GERD, dysphagia, weakness, chronic kidney disease, atherosclerosis, major depression, head injury, hyperlipidemia, epilepsy, anemia, cognitive impairment, osteoporosis, elevated body mass index, obesity status. Gradual weight loss therapeutic/desired, dated 6/23/25. Interventions included serve diet as ordered, monitor intake and record every meal, and provide assistance with all meals as needed. Review of Resident #71’s Nutrition Risk Assessment, dated 6/23/25 noted chewing difficulties due to missing teeth. Interventions were “recommend mechanical altered diet.” A follow-up interview was conducted on 8/28/25 at 12:15 p.m. with Resident #71. The resident stated he/she often received food that was not cut up in small pieces. Resident #71 said he/she needs assistance due to a broken left wrist as well as difficulty swallowing. The resident said he/she occasionally had a hard time swallowing the food that was delivered from the kitchen. Resident #71 said when he/she struggles with the food she will ask staff for something else, “if they will listen.” The resident said he/she had asked multiple staff members to have the dietician come discuss his/her diet and making sure they are getting something they can eat. Resident #71 said it would be very helpful if the diet was fixed and food came up that he/she could eat. An interview was conducted on 8/28/25 at 1:32 p.m. with the Registered Dietician (RD). He said he did Resident #71’s Nutrition Risk Assessment on 6/23/25. He said he remembered the resident talking about having difficulty swallowing. He said he recommended a mechanically altered diet. The RD said he would expect the kitchen to be cutting the resident’s food into small bites if that is the instructions on her tray card. He said if a resident had swallowing issues, he would often request a speech therapy evaluation, but he does not recall if he did for Resident #71. The RD followed up on 8/28/25 at 3:34 p.m. and said he reviewed the resident’s record and said his/her meat was to be cut up in small pieces due to her missing some teeth and having difficulties cutting with a broken wrist. An interview was conducted on 8/28/25 at 1:53 p.m. with Staff HH, Physical Therapy Assistant (PTA). Staff HH reviewed Resident #71’s therapy records and said he did not see any record of the resident being seen for speech therapy. (continued on next page)

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Aventura at the Bay	10300 4th St N Saint Petersburg, FL 33716

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F 0806 Level of Harm - Actual harm Residents Affected - Few	A follow-up interview was conducted on 8/28/25 at 2:35 p.m. with the DON. The DON said no education was completed or processes changed related to meal service and allergies after the incident on 8/15/25 with Resident #169 because the facility didn’t know she had a fish allergy. The DON said, “We don’t know not to give them something if they don’t tell us they have an allergy.” When the DON was told Resident’s hospital records and provider notes both showed the resident’s fish allergy she stated “I don’t read his notes. There are 200 residents here.” The DON reviewed Resident #169’s medication record and confirmed both the hospital record and provider note was in Resident #169’s medical record at the facility prior to the incident on 8/15/25. The DON said she would expect the facility to know the resident had a fish allergy if it was in the medical record. The DON also said she would expect the kitchen staff to know what is in the food that is served. Regarding Resident # 71 the DON reviewed the photo of the meal when the resident was served a full piece of meat and said she would expect the food to be served right. 3) 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’d like a hot dog or hamburger. She confirmed that staff have talked to her about her food preferences and dislikes. 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. Further observations of the tray revealed a meal ticket which had gravy under dislikes. Resident #171 gave permission to take photo evidence of her meal and meal ticket. 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’s on her meal ticket. She said she told the 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: … 3oz[ounce]/2c[cup] Chef Salad (Mo, We, Fr) [Monday, Wednesday, Friday] …” 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. A review of Resident #171’s admission record revealed an admission date of 3/5/24. Further review of the admission record revealed 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. A review of Resident #171’s quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, cognitively intact. A review of Resident #171 orders revealed, dietary consult to discuss food preferences as needed for pt [patient] request dietary consult,” with an order date of 5/21/25. A review of Resident #171’s progress notes and forms/assessments, after 5/21/25, revealed no documentation of a nutrition or dietary consultation regarding the resident’s food preferences. (continued on next page)

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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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F 0806 Level of Harm - Actual harm Residents Affected - Few	4) 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. A review of Resident #172’s admission record revealed an original admission date of 6/7/24 and re-admission date of 5/23/25. Further review of the admission record revealed diagnoses to include atherosclerotic heart disease of native coronary artery without angina pectoris, morbid (severe) obesity due to excess calories, diverticulitis of intestine, part unspecified, without perforation or abscess without bleeding, and hyperlipidemia. A review of Resident #172’s comprehensive MDS, dated [DATE], revealed a BIMS score of 15, cognitively intact. A review of Resident #172’s meal ticket revealed the following under dislikes, “Gravy, Sausage, Beans (Pinto Beans), Greens (Turnip).” On 8/26/25 at 5:17 p.m., an interview was conducted with the Certified Dietary Manager (CDM). He said the residents’ likes and dislikes are on their meal ticket. The CDM said there is no other form used such as a preference sheet. He confirmed the food committee meets once a month. He said he had three months of food committee minutes. The CDM said he gave them to the previous administrator and doesn’t know if the facility has record of them. A review of food committee minutes revealed the following: - 3/4/25, “… 7) We are still getting tickets wrong. Need to make sure that we check them better …” - 4/1/25, “… 7) We are still getting tickets wrong. Need to make sure that we check them better …” - 6/10/25, “ … 1) Reviewed the minutes from April 1th [first] Meeting. The residents talked about the issues that still are happening … 7) We are still getting tickets wrong. Need to make sure that we check them better. Did inservice with tickets again … “ - 7/1/25, “… 1) Reviewed the minutes from June 10th Meeting. The residents talked about the issues that still are happening. … 7) We are still getting tickets wrong. Need to make sure that we check them better. Did inservice with tickets again …” - 8/5/25, “… 7) We are still getting tickets wrong. Need to make sure that we check them better. Did inservice with tickets again. … ” (continued on next page)

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F 0806 Level of Harm - Actual harm Residents Affected - Few	A review of an in-service, provided by the CDM, that was conducted on 7/1/25 revealed it was regarding ticket and tray accuracy with notes to include the following: “Allergies: … Always double check trays for potential allergy foods! … Dislikes: … Be sure preferences are always followed! … Before sending the tray: 1. Right Diet? 2. Right Liquids? 3. Allergies reviewed and compared? 4. Food preferences reviewed and compared? Remember: if a resident receives a wrong diet, or something that’s an allergy, it could be their last meal. Do you want to be responsible for that mistake?” 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 residents’ requests of food choices. The CDM said if a resident doesn’t want the main entrée, 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, “If he gets the message.” He confirmed he is aware of meal ticket accuracy concerns and has conducted audits. The CDM said the last meal ticket and tray accuracy audit was conducted about four months ago. He discussed the recent incident with Resident #169. He said her meal ticket previously had shellfish and crab as an allergen. The CDM said Resident #169’s meal ticket now has fish listed as an allergen, but it previously did not. The CDM said he looked at the ingredients after the incident and found out the fish sandwich that was provided had [NAME], salmon, [NAME], [NAME], squid, and New Jersey bluefish. He said he did not know squid was considered shellfish, and thought the meal had no shellfish. The CDM said he was the one serving during that meal and recalled the dietary aid calling out the food and allergen. He said he found out the next day Resident #169 had an allergic reaction that required the use of an EpiPen. The CDM confirmed he has spoken to the resident before and after the incident. He said Resident #169 has a long list of dislikes, but he is waiting on her family member to provide that information. He confirmed the resident should not have been provided that meal because of the shellfish allergy. The CDM said he has provided in-services and re-education to staff. He said he has the staff on the tray line read the meal ticket back to him and tries to position staff in a way that the end person catches any discrepancies. He said the main issues with meal tray accuracy are residents not receiving condiments or salad dressing but no salad. The CDM said he brings up those issues to the staff member who checks the meal tickets and tray items. He said he thinks the dietary staff are making mistakes or not paying attention when on the tray line. 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. A review of the facility’s policy titled, “Tray Identification,” dated 6/2025, revealed the following under policy interpretation and implementation, “…2. The Food Services Manager or designee will check trays for correct diets before the food carts or meal trays are transported to their designated areas. 3. Nursing staff shall check each food tray for the correct diet before serving the residents. 4. If there is an error, Nursing will notify the Dietary Department immediately so that the appropriate food tray can be served.” (continued on next page)

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F 0806 Level of Harm - Actual harm Residents Affected - Few	A review of the facility’s policy titled, “Food and Nutrition Services,” dated 10/2017, revealed the following, “Each resident Is provided with a nourishing, palatable, well- balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.” Further review of the policy, under policy interpretation and implementation, revealed the following, “…4. Reasonable efforts will be made to accommodate resident choices and preferences. … 7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature. a. If an incorrect meal is provided to a resident, or a meal does not appear palatable, nursing staff will report it to the Food Service Manager so that a new food tray can be issued. …” A review of the facility’s policy titled, “Food Allergies and Intolerances,” dated 8/2017, revealed the following, “Residents with food allergies and/or intolerances are identified upon admission and offered food substitutions of similar appeal and nutritional value. Steps are taken to prevent resident exposure to the allergen(s).” Further review of the policy, under assessments and interventions, revealed the following, “1. Residents are assessed for a history of food allergies and intolerances upon admission and as part of the comprehensive assessment. 2. All resident reported food allergies and intolerances are documented in the assessment notes and incorporated into the resident’s care plan. … 5. Residents with food intolerances and allergies are offered appropriate substitutions for foods that they cannot eat. …” A review of the facility’s policy titled, “Resident Food Preferences,” dated 7/2017, revealed the following, “Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the resident’s or representative’s consent.” Further review of the policy, under policy interpretation and implementation, revealed the following, “1. Upon the resident’s admission (or within twenty-four (24) hours after his/her admission) the Dietitian or nursing staff will identify a resident’s food preferences. 2. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. 3. Nursing staff will document the resident’s food and eating preferences in the care plan. …”

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. (continued on next page)

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interviews and record review, the facility failed to offer a nourishing evening snack for seven residents (Resident #3, #131, #33, #181, #108, #60, and #10) out of seven residents sampled for dining. Findings included: During a Resident Council meeting on 08/27/2025 at 11:15 a.m., Resident #131 stated residents were not offered evening snacks. She stated she was aware snacks were available on the floors, just not being offered by the staff. Also, stated she'd asked for an evening snack from staff more than once and was told they were out of snacks or didn't have any left. During Resident Council meeting on 08/27/2025 at 11:15 a.m., Resident's #33, #3, #181, and #108 voiced concerns regarding the snacks. Resident #33 stated she had been told more than once snacks were not available at night. Resident #3 stated only one CNA (Certified Nursing Assistant) regularly offered snacks, usually offered cookies, on nights he worked. Residents #33, #3, #108, and #181 all agreed stating they would enjoy an evening snack as there is a large time gap between dinner and breakfast. During an interview on 08/27/2025 at 4:00p.m., Resident #10 stated not being offered an evening snack and would love if the facility would offer a snack in the evening as she didn't enjoy the food for the main meals and often ordered out. During an interview on 08/27/2025 at 4:23p.m. , Resident #60 stated not being offered an evening snack and needed to have one as being a diabetic. She stated there is one CNA who would offer residents cookies or crackers when he worked nights, but he was the only one who walked around offering snacks. During an interview on 8/27/25 at 3:44 p.m. with Staff II, Licensed Practical Nurse (LPN), stated snacks are available on the unit. The LPN stated if a resident is diabetic or has an order for a snack, a snack is supposed to be taken to the resident. Staff II stated residents would need to ask the staff if they wanted a snack, the staff do not offer an evening snack to all residents. During an interview with resident #131 on 08/28/2025 at11:30a.m., the resident voiced she was not offered evening snacks regularly. Resident stated depending on who her CNA was for the evening shift she would sometimes be brought a snack if she'd asked for one, however it was never just offered to all residents. Stated she had been told more than once by the staff no snacks were available when she'd asked.During an interview on 08/28/2025 at 3:27 p.m., the Dietary Manager (DM) verified there was a 15-hour gap between dinner and breakfast. The DM stated snacks such as crackers, cookies, and sandwiches are delivered to the units before lunch in case residents want something in between meals. The DM did not know whether the staff were offering them to the residents, but residents should receive a snack if they ask for one. Review of the facility's Meal Delivery Schedule, dated 10/28/2024, revealed: - Dinner: C Wing: 4:00-4:30 p.m., A wing: 4:30-5:00 p.m., Main Dining Room: 5:0-5:15p.m., B wing: 5:15-5:30p.m., D wing: 5:30-5:45p.m.- Breakfast: C wing: 7:00-7:30a.m., A Wing: 7:30-8:00a.m., Main Dining Room: 8:00-8:15a.m., B Wing: 8:15-8:30a.m., D Wing: 8:30-8:45a.m.- Meal Delivery Schedule revealed 15 hours between dinner and breakfast for all wings as well as the Main Dining area.Review of the facility Policy titled Resident Dining Services revealed the following: Purpose:The facility will follow these guidelines to ensure meals are served in a pleasant atmosphere, diets are being served as ordered by the physician, foods are at appropriate temperatures and meet the individual residents' needs.Steps:1. Dining location will be determined based on resident preference and needs. The interdisciplinary team will assist with decisions if needed.2. The Director of Food and Nutrition Services develops a process that indicates the order in which residents are to be served in dining rooms and room trays. This process is updated as needed.3. Nursing staff will assist residents to appropriate dining locations in a timelymanner.4. Mealtimes will be posted in a central location and will be comparable to normal times in the community.5. Residents seated together will receive meals at the same time (served by table) so that they may dine together.6. Staff members assigned to passing meal trays will practice proper hand hygiene techniques (handwashing or use of hand sanitizer) between each table served in the dining room, or each resident served on the hall.7. Food transported through hallways will be completely covered.8. Only Licensed Nurses, Certified Nursing Assistants, Therapists, or trained and certified staff may feed residents per state regulations.9. The time between the evening meal and breakfast will not exceed 14 hours unless a substantial snack is served at HS. When a substantial HS snack is served, up to 16 hours may elapse between an evening meal and breakfast the following day if a resident group agrees to this meal span.10. Residents who wish to eat outside of the scheduled meal times will have access to an always available menu that provides the equivalent nutritional content to meet the recommended dietary guidelines.

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**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 whey 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

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations, interviews, and record review the facility failed to ensure the large outside trash compactor area was free from refuse and trash debris during one of one days observed (8/25/2025). Findings included: On 8/25/2025 at 9:35 a.m. the Kitchen Manager provided an outside tour of the facility in the back alley way. During the observation, there was a very large tan colored trash compactor/dumpster positioned in the alley on a non porous surface. The trash compactor door was observed closed. However, further observations revealed many pieces of trash/refuse on the ground on either side, and the back behind and front of the compactor. The refuse/debris included used/soiled clear plastic gloves, clear full bags of opened trash/refuse, used/soiled plastic Styrofoam containers, many used plastic straws, and loose used crumpled napkins and paper. Photographic evidence was taken. On 8/28/2025 at 1:00 p.m. an interview with the Maintenance Director revealed they have been having issues with trash debris surrounding the trash dumpster/compactor. He revealed the trash/refuse comes from all departments and the department staff are continually educated on how to properly dispose of the trash/refuse. The Maintenance Director also confirmed they do have many ducks in the area and they do get to the trash dumpster/compactor and the staff try to do their best to keep them away. The Maintenance Director did not have any documentation to support continued monitoring of the dumpster/compactor area. On 8/28/2025 the Kitchen Manager and Maintenance Director provided the facility's Procedure Trash Compactor policy with no revision date for review. The policy stated; 1. Collect trash in garbage liners in cans, 2. Roll out to compactor, 3. Place in compactor close door, 4. Push the compactor button to compact garage.The policy did not specify the routine cleaning maintenance of the trash compactor or it's surrounding area.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure the residents or their representatives acknowledged understanding of the binding arbitration agreement and the agreement is not required as a condition of admission or as a requirement to continue to, receive care for three residents (#19, #117 and #215) of three residents sampled. Findings included: 1. On 8/27/25 at 10:04 a.m., an interview was conducted with the Nursing Home Administrator (NHA). She presented a list of residents who have recently signed arbitration agreements. Review of the admission Record for Resident #19 revealed an admission date of 7/24/25 with diagnoses to include Type 2 diabetes, peripheral vascular disease; acquired absence of right leg above knee and other co-morbidities. Review of the admission Minimum Data Set (MDS), dated [DATE], showed Resident #19 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Review of the admission Agreement attachment titled, Agreement to Resolved Disputes by Binding Arbitration was signed by Resident #19 and the facility admission Director on 7/27/25. On 8/28/25 at 6:41 p.m., an interview was conducted with Resident #19. The resident recalled signing a bunch of papers on admission, and a lady going through all the papers. 2. Review of the admission Record for Resident #117 revealed an admission date of 7/23/25 and re-admission of 8/5/25 with diagnoses of Chronic Obstructive Pulmonary Disease with (acute) lower respiratory infection (COPD), Atrial Fibrillation (A-Fib), endocarditis, and other co-morbidities. Review of the MDS, dated [DATE], showed Resident #117 had a BIMS score of 15 out of 15, indicating intact cognition.Review of the admission Agreement attachment titled, Agreement to Resolved Disputes by Binding Arbitration was signed by Resident #117 and the facility admission Director on 8/6/25. On 8/28/28 at 6:35 pm. , an interview was conducted with Resident #117. Resident #117 stated not being sure of signing paperwork upon admission as being ill at admission and not being in the right frame of mind. 3. Review of the admission Record for Resident #215 revealed an admission date of 8/20/25 with diagnoses of neoplasm (cancer) related pain and other co-morbidities. Review of the MDS, dated [DATE], showed Resident #215 had a BIMS score of 14 out of 15, indicating intact cognition. Review of the admission Agreement attachment titled, Agreement to Resolved Disputes by Binding Arbitration was signed by Resident #215 and the facility admission Coordinator on 8/25/25. On 8/28/28 at 6:33 pm, an interview was conducted with Resident #215. Resident #215 stated recalling signing the admission paperwork and was not sure if the documents were optional. During an interview on 08/28/2025 at 5:42 p.m. the admission Coordinator (AC), stated being responsible along with the admission Director (AD) for ensuring residents admitted to the facility have signed the appropriate admission documents, including the Arbitration Agreement which is part of the admission paperwork. The AC explained the arbitration agreement is discussed with all residents admitted . The arbitration agreement is between the facility and the resident. If the resident signs the arbitration agreement, the resident is agreeing to not seek legal action against the facility but go to arbitration with the facility and themselves. We explain to them how to make a request, and the agreement is a legal document. We tell the residents they do not have to sign the agreement, although I do not see in the agreement where it states it is optional. The AC continued to state not being able to find in the agreement the residents can still contact state personnel if they would like to. During an interview on 8/28/25 at 6:30 p.m. the NHA stated being new to the facility and has not had a chance to read the agreement. A policy and procedure for the signing of the arbitration agreement was requested and the NHA stated on 8/28/25 at 6:35 p.m. that they are looking for the policy but don't think we have one.

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	105688	A. Building B. Wing	08/28/2025

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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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide a neutral and fair arbitration process and agree to arbitrator and venue. Based on record review and interviews, the facility failed to ensure the arbitration agreement provided for the selection of a neutral arbitrator agreed upon by both parties for three (#19, #117 and #215) of three residents sampled. Findings included: Review of the Agreement to Resolve Disputes by Binding Arbitration revealed under section C. Who Will Conduct Arbitration. The Arbitration shall be conducted by the American Health Lawyers Association (AHLA) through its Alternative Dispute Resolution (ADR) service. If the AHLA process is no longer in existence at the time of the dispute, or AHLA is unwilling or unable to conduct the arbitration, then facility shall choose another independent entity that is regularly engaged in providing ADR services to conduct the mediation or arbitration.The form was signed by Resident #19 on 7/27/25.The form was signed by Resident #117 on 8/6/25.The form was signed by Resident #215 on 8/25/25.During an interview on 08/28/2025 at 5:42 p.m. with the admission Coordinator (AC), stated the agreement does not appear to give the resident a choice for arbitration. During an interview on 8/28/25 at 6:30 p.m. the NHA stated being new to the facility and has not had a chance to read the agreement. A policy and procedure for the signing of the arbitration agreement was requested and the NHA stated on 8/28/25 at 6:35 p.m. that they are looking for the policy but don't think we have one.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure an effective infection control program was implemented related to: a) improper use of Personal Protective Equipment (PPE); b) contact/isolation signs not posted and precautions not followed by staff; and c) hand hygiene practices were not conducted properly in four of four wings observed.Findings included: 1) On 08/25/2025 Observed room [ROOM NUMBER] to have Special Contact/Droplet isolation sign posted at the door. PPE caddy was present at the door Resident from room observed wheeling herself through the hallways and interacting with staff, resident was not wearing any mask. Interviewed Staff AA, unit clerk on 08/25/2025 at 10:25AM. She stated the resident was on Special Contact/Droplet precautions for the wound on her foot. Voiced resident had a wound vac requiring the isolation precaution. Interview with Staff Y, RN manager on 08/26/2025 about resident's precaution and she stated the resident was exposed to covid because her roommate was positive for COVID, however the resident never exhibited any symptoms, so she was free to go around the facility. Stated the resident also left the facility a few days per week to attend mental health classes. Interview 08/27/2025 at 12:16PM with Staff BB, Certified Nursing Assistant (CNA). CNA stated she didn't have room [ROOM NUMBER] on that day, however, she previously had her many times, and stated her Special Contact/Droplet precautions were for the wound on her foot. Staff BB voiced the only time they were required to wear the PPE was when they were doing direct patient care. Two observations were made, one on 08/25/2025 at 10:20AM and another on 08/27/2025 at 12:15PM, of staff entering room [ROOM NUMBER] without proper PPE for special contact/droplet precautions. 2. An observation was conducted on 8/25/2025 at 10:06 a.m. room [ROOM NUMBER] and room [ROOM NUMBER] had a personal protective equipment (PPE) caddy hanging from the door. No isolation sign was present. An interview was conducted on 8/25/2025 at 10:21 AM outside room [ROOM NUMBER]. Staff A, Unit Manager (UM) stated she/he was not sure of the isolation precautions but would find out. An interview was conducted on 8/25/2025 at 10:30 AM with Staff JJ, Certified Nursing Assistant (CNA). The staff member stated if there is no sign it probably means they don’t have anything so there is no need to put any PPE on. An observation and interview was conducted on 8/25/2025 at 10:36 a.m. with Staff A, UM. Staff A was observed placing a special contact droplet isolation sign on the door. Staff A stated the residents in room [ROOM NUMBER] and room [ROOM NUMBER] were positive for COVID-19 and the signs should have been on the door. Staff A stated PPE would be required to enter the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted on 8/28/2025 at 5:26 p.m. with the Infection Preventionist (IP). The IP agreed with the following; the proper isolation signage should be posted outside the door to the room, the staff members should be following the correct PPE requirements, foley catheter should not be hanging from a trash can, and staff should understand what the isolation precautions are for. 3. An observation was conducted on 8/26/25 at 4:55 p.m. of Staff R, LPN. Staff R was observed administering an injection to a resident in the hallway next to the medication cart. After Staff R completed the injection, he/she poured a cup of water, handled items inside the mediation cart and administered pills to the resident. Then proceeded to another resident room. No hand hygiene was completed throughout the process. An observation and interview was conducted on 8/2/25 at 5:08 p.m. with Staff R. Staff R was observed entering a resident room to check a resident’s blood glucose level. Staff R carried the bottle containing glucose monitoring strips into the resident room and set it on the resident’s bedside table with no barrier. Upon completion of the blood glucose check, Staff R returned the bottle containing blood glucose monitoring strips to the medication cart without cleaning the bottle. Staff R confirmed the bottle was placed in the cart without being cleaned. He/she also confirmed the bottle of strips was not for that individual resident but for all residents that needed their blood glucose checked. Staff R said hand hygiene should have been completed after the resident’s injection and prior to gathering medications and again prior to entering another resident room. An observation was conducted on 8/28/25 at 12:51 p.m. of Staff EE, RN. Staff EE was observed entering a resident room to take their blood pressure. He/she placed the blood pressure cuff on the resident’s bed with no barrier, then moved the blood pressure cuff to the resident’s bedside table. After completing the tasks in the resident’s room, Staff EE exited the room and placed the blood pressure cuff on top of the medication cart with no barrier and without cleaning it. An observation was conducted on 8/25/25 at 10:46 a.m. of a respiratory mask sitting on a table uncovered in room [ROOM NUMBER]. The resident said the mask was always left standing up on the machine and he/she had never seen it in a bag. The mask remained sitting out uncovered on 8/27/25 at 2:22 p.m. An interview was conducted on 8/28/25 at 2:17 p.m. with the DON. The DON said hand hygiene should always be completed after an injection and between each resident room. She also stated the blood pressure cuff should not have been taken from a resident room and placed on the medication cart without being cleaned first. The DON also confirmed respiratory masks should be placed in bags in resident rooms, not be left sitting out on the table uncovered. 4. On 8/25/25 at 10:01 a.m., an observation of room [ROOM NUMBER] revealed there were two precaution signs on the door. Further observations of the signs revealed one was for enhanced barrier precaution (EBP) and the other was for contact precautions. An observation of the inside of room [ROOM NUMBER] revealed Staff C, Housekeeping Aide had a mask and gloves on, but no gown. On 8/25/25 at 10:20 a.m., an observation of Resident #172 was conducted. He was laying down in bed and the foley catheter was observed clipped to the garbage can, with garbage inside, and the bag was touching the floor. He said it is there because that was the lowest position. Resident #172 said sometimes he or staff puts the catheter bag on the garbage. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/25/25 at 12:07 p.m., an observation of Staff A, Licensed Practical Nurse (LPN)/Unit Manager (UM) was observed with longer than ¼ inch, artificial nails with multiple gems on them. On 8/25/25 at 4:39 p.m., an observation of dinner tray passing revealed Staff K, CNA went into room [ROOM NUMBER] without any personal protective equipment (PPE) on. An observation of the wall next to the door of room [ROOM NUMBER] revealed the EBP and contact precaution signs were still there. On 8/26/25 at 10:30 a.m., an attempt was made to interview Staff C, Housekeeping Aide, however, she said she did not speak English. On 8/26/25 at 10:35 a.m., Staff C, Housekeeping Aide was interviewed with the assistance of Staff D, Floor Technician. Staff C, Housekeeping Aide said for rooms with an EBP sign, she puts on gloves and a gown. She said for residents with COVID-19, she puts on a mask. Staff C, Housekeeping Aide said she knows a resident had COVID-19 because she hears them coughing. She said before entering a room with contact precautions, she first uses hand sanitizer, then puts on gloves and a gown. She said her supervisor educated her on what the different precaution signs mean and the appropriate PPE to put on. A review of Resident #172’s admission record revealed an original admission date of 6/7/24 and re-admission date of 5/23/25. Further review of the admission record revealed diagnoses to include malignant neoplasm of bladder, unspecified, urinary tract infection, site not specified, extended spectrum beta lactamase (ESBL) resistance, need for assistance with personal care, and unsteadiness on feet. A review of Resident #172’s comprehensive MDS, dated [DATE], revealed a BIMS score of 15, cognitively intact. A review of Resident #172’s physician orders revealed the following to include: - “Indwelling Urinary Catheter care every shift with soap and water. every shift for Catheter,” with a start date of 5/23/25. - “Indwelling urinary catheter 20 FR [French] 30 cc [cubic centimeters] to straight drainage for diagnosis of malignant neoplasm of bladder,” with a start date of 5/27/25. A review of Resident #172’s progress notes from 8/20/25 to 8/27/25 revealed no documentation related to the resident’s preference of putting the catheter bag on the garbage can. A review of Resident #172’s care plan revealed the following to include: - “The staff have identified that I am at risk for falls r/t [related to] emphysema, COPD [chronic obstructive pulmonary disease], morbid obesity, psychotropic drug use, incontinences, possible s/e [side effects] of medications. Date Initiated: 06/10/2024 …” - “At times I can refuse to have my Foley catheter check for placement Date Initiated: 03/06/2025 . ” (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- “[Resident name] can be noncompliant with medication as ordered. He is not always easily redirected r/t [related to]. Patient education and 1:1 [one to one] in regard to prescribed medication, use, health condition and risks of noncompliance. Staff will continue to encourage compliance, redirect as able. Physician aware. Date Initiated: 05/24/2025 …” - “[Resident name] resistive to care,medications, treatments, ADl's [Activities of Daily Living] At times I will refuse medications, treatments, ADL,showers. labs/care, showers, and lab diagnostics. Date Initiated: 11/21/2024 …” - “I utilize an indwelling catheter due to obstructive and reflux uropathy, bladder cancer Date Initiated: 06/10/2024. …” with interventions to include the following, “Check position of leg strap/anchor for placement as per orders Date Initiated: 02/27/2025 … Keep catheter bag below the level of the bladder. Date Initiated: 12/12/2024. …” On 8/27/25 at 12:11 p.m., an observation of Resident #172 revealed the same concerns observed on 8/25/25 related to the catheter bag. The resident gave permission to take photographic evidence. On 8/27/25 at 12:26 p.m., an interview was conducted with Staff B, LPN who confirmed Resident #172 is in her assignment today. She said she follows orders for catheter care and bag placement. Staff B, LPN said she last saw Resident #172’s catheter bag clipped to the side of the bed. She said she’s had this resident a few times and has never seen the catheter bag anywhere else besides the side of the bed. Staff B, LPN said it would not be okay for it to be clipped on to the garbage can. On 8/27/25 at 12:31 p.m., an interview was conducted with Staff A, LPN/UM. An observation of her nails revealed the same concerns observed on 8/25/25. She confirmed Resident #172 moves the catheter bag to the garbage. Staff A, LPN/UM said he walks and has the ability to move it to the garbage. She said it is not okay to have the catheter bag clipped to the garbage. Regarding EBP signs, Staff A, LPN/UM said if staff are having contact or providing care to the resident they need to wear a gown and gloves. She said if it’s delivery of a meal tray or providing medicine to a resident the staff do not need to wear PPE. She said for contact precautions, if care is being provided then a gown, gloves, and mask need to be worn. Staff A, LPN/UM said if there’s no contact with a resident, and they are on contact precautions, then PPE does not need to be worn. She said if it was a housekeeping staff member going into a room with contact precautions, she would advise them to put on a gown. She stated, “If it’s just to mop and clean, ” then the housekeeping staff would not need to wear PPE. On 8/28/25 at 10:38 a.m., an interview was conducted with the Risk Manager (RM)/Infection Preventionist (IP). She said a resident is care planned depending on the behavior, what they are refusing, and if it is an acute or on-going behavior. She said a catheter bag should not be clipped to the garbage can or touching the floor because it is an issue of risk of pathogens. The RM/IP said if Resident #172 puts the catheter bag on the trash can, there should be a care plan for resident preference. She confirmed Resident #172’s care plan was updated today for putting the foley bag on the trash can. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility’s policy titled, “Handwashing/Hand Hygiene,” with a revision date of October 2023, revealed the following, “ … Indications for Hand Hygiene 1. Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. After touching the resident’s environment; f. Before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal.” Further review of the policy revealed the following, “Promoting Healthy Hand Skin and Fingernails a. Personnel with direct-care resident responsibilities should maintain short, natural fingernails. a. Fingernails should not extend past to fingertips. b. Wearing artificial fingernails is strongly discouraged among staff members with direct resident-care responsibilities and is prohibited among those caring for severely ill or immunocompromised residents. …” A review of the facility's policy titled, Catheter Care, Urinary, revised August 2022, revealed the following, . Infection Control . 2. Be sure the catheter tubing and drainage bag are kept off the floor.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to ensure two residents (#23, #90) were offered the COVID-19 vaccine out of 5 residents sampled for COVID-19 immunizations.Findings included:1. A review of Resident #23's admission Record revealed the resident was admitted to the facility on [DATE].Further review of the medical record revealed Resident #23 was sent to the Emergency Department on 8/15/2025. The resident tested positive for COVID-19 at the Emergency Department and was re-admitted to the facility on [DATE].A COVID-19 vaccine consent or refusal was not found in the medical record prior to 8/15/2025.2. A review of Resident #90's admission Record revealed Resident #90 was admitted to the facility on [DATE]. Further review of the medical record revealed the resident was sent to the Emergency Department on 08/17/2025 and was diagnosed with COVID-19. The resident was re-admitted to the facility on [DATE].A COVID-19 vaccine consent or refusal was not found in the medical record prior to 8/17/2025.An interview was conducted on 8/28/2025 1:42 p.m. with the Infection Preventionist (IP). The IP stated both residents were not offered covid vaccines upon admission, but they should have been since that is part of their admission process. The IP went on to state she/he is unsure why it wasn't done.A review of the Policy titled Vaccination of Residents with a revision date of August 2025 revealed the following: Policy: All residents are offered recommended vaccines unless the vaccine is medically contraindicated. Policy interpretation and Implementation: 1. Upon admission residents are evaluated for current vaccine status and potential clinical contraindications for receiving vaccines.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure a functioning call light system for four residents (#169, #125, #147, and #84) out of four residents sampled for call lights. Findings included: An interview was conducted on 8/25/25 at 11:03 a.m. with Resident #169. He/she said after admission it was discovered the call light didn’t work and it was reported. Residen#169 said it took until the next day until the call light was fixed, and he/she was not provided a hand bell or anything to get staff’s attention. Review of admission Records showed Resident #169 was admitted on [DATE]. Review of Resident #169 admission Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, showed a brief Interview for mental (BIMS) score of 15, indicating she was cognitively intact. An interview was conducted on 8/25/25 at 5:00 p.m. with Resident #125. Resident #125 stated the call light was not working. He/she was unsure of when it worked last but notified staff early that morning and was told it was reported to maintenance. The resident was observed pushing the call light button and the light in the room did not light up and the lights/sound outside the room did not trigger. Review of admission Records showed Resident #125 was admitted on [DATE]. Review of Resident #125 BIMS, dated 7/29/25, showed a score of 13 indicating he/she is cognitively intact. An observation and interview was conducted on 8/25/25 at 5:41 p.m. with Staff Y, Unit Manager (UM). Staff Y was observed entering Resident #125’s room and testing the call light. Staff Y confirmed the call light did not function inside or outside the room. Staff Y said this was the first they had heard of the light in the resident’s room not working. Staff Y said if staff were notified it should have been reported and fixed immediately. An interview was conducted on 8/25/25 at 5:54 p.m. with the Nursing Home Administrator (NHA). The NHA was unaware of call light issues and stated she would do a full house audit. She said her expectation would be for all call lights to be functioning. Review of the audit provided by the NHA showed the first full house audit was completed on 8/25/25 from 6-6:45 p.m. During that audit it was discovered the call light was not working in 128A and 315A. It was also discovered the call light did not work for the resident in 406A. A second full house call light audit was conducted on 8/25/25 during the 11 p.m. – 7:00 a.m. shift on 8/26/25. There were no additional call light concerns noted. A third full house call light audit was conducted on 8/26/25 from 6:30-7:30 a.m. room [ROOM NUMBER] A was discovered to not have a call light in place. room [ROOM NUMBER] was found to have a non-working call light. room [ROOM NUMBER] B was found to not have a functioning call light. The NHA said all of the problems were corrected. (continued on next page)

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 8/28/25 at 6:15 p.m. with the Maintenance Director. He said maintenance tests call lights in eight random rooms each month to ensure they are functioning. He said staff should put a request in the maintenance system when they find a call light issue. The Maintenance Director said no request was made and no one notified him on 8/25/25 of the call light not working for Resident #125. He said when a new admission came in the maintenance team did pre-admission check lists to ensure a room is ready and part of that is checking the call light for functionality. The Maintenance Director assisted with the full house call light audits on 8/25-8/26/25. He said every room was checked including empty rooms. He said 99% of the time the issue was the call light cord/button, not the main system. On 8/28/25 at 6:38 p.m. the Director of Nursing said there is no policy on call light functioning. 2. On 08/25/2025 at 10:23 A.M., an observation was made of Resident #147’s call light in a dresser drawer, which was closed and out of reach of the resident. Photographic evidence was obtained. On 08/27/2025 at 12:30 P.M., an observation was made of Resident #147’s call light hanging towards the floor from inside the dresser drawer. The Maintenance Director (DOM) walked into the resident’s room and the resident motioned for the call light with an outstretched arm in the direction of the call light. The resident was unable to speak English. The DOM walked over and passed the call light to the resident. Photographic evidence was obtained. On 08/26/2025 at 10:15 A.M., the call light for Resident #84 was observed to not be working. When pressed, the light in the hall did not trigger and staff did not respond after a second pressing of the call light. Staff S, RN UM was notified of the call light for Resident #84, not working and checked and confirmed the call light was not working. Staff S, RN Um stated maintenance would be notified to fix the call light. On 08/28/2025 at 09:39 A.M., an interview was conducted with Staff I, Certified Nursing Assistant (CNA). During the interview, Staff I, CNA stated call lights are placed on resident beds and within reach of residents. If a call light is identified to not be working, the staff notifies maintenance. On 08/28/2025 at 09:59 A.M., an interview was conducted with Staff J, CNA. Staff J, stated call lights should be placed on a resident’s bed if the resident is not in bed and in the resident’s chest area if the resident is in bed. Staff J, CNA stated rooms [ROOM NUMBERS] had non-functioning call lights. Staff J, CNA stated if a call light is not working, maintenance should be notified through a paper form at the nurse station. Staff J, CNA stated there is no reason a call light should be in a drawer. On 08/28/2025 at 10:25 A.M., an interview was conducted with Staff Q, CNA. Staff Q, CNA stated call lights should be in reach of residents. Staff Q, CNA stated if a resident is in bed, the call light would be placed in the resident’s hand or clipped to the bed. Staff Q, CNA stated residents in B wing typically do not use call lights and the residents throw them down. Staff Q, CNA stated there is no reason a call light should be tucked in a drawer. On 08/28/2025 at 11:15 A.M., an interview was conducted with Staff R, Registered Nurse (RN). Staff R, RN stated if a call light is not working, a ticket would be opened in the facility’s maintenance work order system, and it would be assigned critical for maintenance to look at. (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	08/28/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/28/2025 at 12:21 P.M., an interview was conducted with Staff S, Registered Nurse Unit Manager (RN UM). Staff S, RN UM stated call lights should be placed within reach of the residents, so the residents could use the call lights. Staff S, RN Um stated the call light should not be tucked in a bed, wrapped around rails, and not put away. Staff S RN UM explained being aware of call lights not working. Staff S, RN UM stated the system for call lights was not down, only a few call lights were not working. Staff S, RN UM stated residents don’t really use call lights, only a few residents use them.