

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/05/2025
NAME OF PROVIDER OR SUPPLIER  Aviata at the Gardens - Tallahassee		STREET ADDRESS, CITY, STATE, ZIP CODE 1650 Phillips Rd Tallahassee, FL 32308	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, resident and family interviews and record reviews, the facility failed to provide a safe, clean, comfortable, and homelike environment for 3 of 10 residents reviewed. The findings include:</p> <p>On 12/2/25 at approximately 12:00 pm, tour of the facility was conducted on the 100/200/300 halls. Upon entry to the unit, by the nurse station, a strong odor of urine permeated throughout the hallways. Again, on the same day at approximately 3:00 pm, the strong odor continued throughout the halls. On 12/3/25 at approximately 10:00 am, a second tour of the 100/200/300 halls revealed the strong odor of urine still existed.</p> <p>On 12-3-25 at 11:06 am, an interview with Resident #9's family member revealed Last week at 10:30 am, the hall was a mess I found him filthy, dirty, and soaking wet. She stated hospice is now coming for him 3 times a week. When hospice aides come and bathe him, they call and say they found him in a mess. The family member stated she is at the facility at least 4 times per week and there is always a bad smell of urine on the halls. She stated , That smell is probably because the staff strip the beds and leave all the sheets/linens at the foot of the bed, then they come back after doing all the other beds and pick/bag up the clothes, leaving them there stinking for an extended period of time.</p> <p>Resident #6</p> <p>On 12-2-25 at 12:07 pm an interview with Resident #6 revealed she has had cockroaches in her room. She stated her daughter purchased a glue pad because the facility is not doing anything about the problem. An observation of the floor under the air conditioner (AC) revealed a glue pad that had several cockroaches and a very small roach running on the floor along side the glue pad. (Photographic evidence obtained) A second observation of the resident's room was conducted on 12-3-25 at 10:00 am and revealed the glue pad contained more roaches.</p> <p>On 12-5-25 at 11:19 am an interview with the Maintenance Director revealed that he recently had the pest control change from spray to dust in order to address the roach problem. He also stated they bought the glue strips and placed them in resident rooms under the AC unit. When asked why there are so many live roaches, he really did not have an explanation. At this time, he confirmed the pest control has not been effective.</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the pest control invoices revealed monthly services on site 2x per month for resident rooms per request/pest sighting logbook. Monthly service also performed for common areas, kitchens/dining areas, housekeeping/laundry, activity/therapy rooms, dry food storage, courtyard, dumpster area, EXT perimeter. Wasp up to 15'. Applied to patients rooms to target nuisance ants, roaches, silverfish and spiders. Review of Pest Sighting Logs for the 400/500/600 halls revealed numerous recent sightings of roaches on 400, 500 and 600 halls between 7-15-25 and 11-21-25. Review of the Pest Sighting Logs for 100/200/300 halls revealed numerous sightings of roaches as recently as 12-2-25 on the 200 and 300 halls.</p> <p>room [ROOM NUMBER]</p> <p>On 12/02/2025, an observation of room [ROOM NUMBER]'s privacy curtain divider showed it was visibly soiled with unknown substances and that Bed B had no pillowcases on pillows and that the pillow is dirty with unknown substance.</p> <p>On 12/02/25 interview room [ROOM NUMBER]B's resident revealed she has been here a week with no linen changes or housekeeping services. The resident stated she has asked repeatedly with no assistance from staff or housekeeping.</p> <p>On 12/02/25 at 2:54 PM, an interview with the Housekeeping Director revealed that the December schedule is not up yet and each month we have a project schedule that is a different task staff focus on besides the daily cleaning. Staff deep clean when a resident moves out of the room, disinfect mattress, pull trash, wipe horizontal down of surfaces, dusting top to bottom, dividing curtains, but there are regular room cleans.</p>		

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F 0686  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing.  (continued on next page)

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based upon record reviews and interview, the facility failed to provide care and services to prevent worsening of wounds for 1 of 1 residents reviewed for pressure ulcers. (Resident #7)The findings include:Upon record review Resident #7 was admitted to facility initially on 5/1/25, was discharged to hospital and re-admitted to the facility on [DATE] with the diagnosis of Peripheral Autonomic Neuropathy, COPD, Rheumatoid Disease, AFIB, and Chronic Respiratory Failure. A Minimum Data Set (MDS) assessment with a date of 5/7/25 revealed that skin conditions is not coded for any pressure areas or ulcers but states she is at risk for pressure ulcers.On 5/16/25 a wound assessment was completed post re-admission from hospital that reveals wound #1 right inner thigh, measuring 4cm x 0.3 cm x 0.1 cm, etiology: pressure ulcer / injury at a stage 2 and not acquired in house. Wound #2 on the left buttocks measured 1.0 cm x 1.0 cm x 0.1 cm, etiology was incontinence associated dermatitis with stage partial thickness and not acquired in house. Daily wound care treatments were initiated. A wound care assessment was completed on 5/28/25 indicating that wound 1 and wound 2 were resolved and healed.A wound assessment was performed on 6/6/25 that reveals a Wound #3 on the Left Heel measuring 3.5 cm x 3.5 cm x 0.0 cm etiology pressure ulcer / injury, unstageable and states that wound was present on admission with the date of 5/15/25. Wound #4 on the right heel measured 0.6 cm x 1.5 cm x 0.0 cm etiology pressure ulcer / injury, unstageable and states that wound was present on admission with the date of 5/15/25.A change of condition nursing assessment was completed on 7/30/25 at 07:20 AM, revealing Resident #7 was sent to an acute care hospital for altered level of consciousness status and an apparent minor wound now developing redness, swelling or pain for right ankle wound.A vascular consult was conducted while Resident #7 was at the hospital dated 08/01/25 revealing she has been generally weak and groggier than usual over the past day or so. She has chronic wounds on her feet, and the facility was concerned they were getting worse and unsure how long the wounds have been present. Left heel wound measured 4.0 cm x 3.0 cm x 0.1 cm unstageable pressure injury with tan / black necrotic tissue, right posterior lower leg with two full thickness wounds measures 20 cm x 7 cm area. These wounds are with black boggy eschar, foul smelling, the eschar is lifting and soft brown moist necrosis. There are areas on sacrum, hips, and posterior thighs and lateral right lower extremity consisting of dark purple hue color and irregular shape. Areas on sacrum and buttocks is beginning to demarcate revealing partial-thickness tissue loss. A weekly skin assessment was conducted by nursing staff on 7/16/25 reveals treatment to bilateral heel in progress with skin intact, weekly skin assessment dated [DATE] reveals treatment in progress skin intact, and on 7/30/25 at 07:43 am reveals right ankle wound treatment in progress, left ankle wound treatment in progress, bilateral buttocks noted with discoloration. Wounds #3 and #4 were not identified on re-admission on [DATE] and was not assessed by wound care until 6/6/25. The wound to right posterior lower extremity was not identified on weekly skin checks and was assessed during facility wound care rounds. Resident 7 was transferred to acute care hospital where she presented with worsening of wounds and right posterior lower leg wounds were identified and treated per hospital documentation on 7/30/25.On 12/5/25 at 12:30 pm, an interview was conducted with the Wound Care Nurse that reveals staff nurses and CNAs will notify her of any skin changes that may occur in residents at the facility. She then reviews and / or assesses the resident with skin issues, perform a second skin assessment, and if needed will add the resident to the wound care rounds for the physician to see. She stated that when Resident #7 was admitted to facility, she had a wound to her bottom and to her heel. She further stated Resident #7 was sent out to the hospital several times and when she returned to the facility, she had bilateral ulcers to her heels and behind her calves. When asked to explain why the wounds to Resident 7 heels were not assessed until 6/6/25 and the wounds to the back of her calves were not identified or assessed on the weekly wound rounds, she did not respond. Upon asking the wound care nurse if she was the only nurse to provide wound care to the residents in the facility she stated that she is unless she is off or has been called off due to overstaffing, then the nurses assigned to the residents will perform dressing changes.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based upon Interviews, observations, and facility policy review the facility failed to ensure and provide routine medications to residents in a timely manner. The facility failed to ensure the controlled drug records are in order, signed out appropriately by administering staff nurses and that all controlled medications are accounted for. While conducting observations of medication carts on 12/2/25 at approximately 3:15 pm, Nurse E opened up the narcotic medication drawer and removed 5-7 narcotic cards. A small white tablet was noted in the bottom of the drawer. She then stated the medication count sheet was blank. But she signed it out because she was told to do that today for the other nurse. On 12/2/25 an interview was conducted with Resident 12 at 08:00 pm, she stated that over the weekend she had to go without her pain medication. She stated was told by a nurse that she forgot to send in a script to the pharmacy for her pain medication. she said, This morning, I asked for a pain pill at 5:00 am and I didn't get it until 6:30 am. Upon review of Resident #12's medication administration record on 12/3/25, it revealed that she only received Tylenol for pain medication from 11/30/25 through 12/1/25. The facility medication administration policy states, .medications are administered in a safe and timely manner. Medications are administered in accordance with prescriber orders, including any required time frame. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and the need for additional training. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. An interview with the Director of Nursing (DON) was conducted on 12/3/25 at 10:00 am. The DON stated she started a program improvement plan for narcotic controlled substances due to a residents' medication card prescription label was marked out and someone wrote in 10 mg. She stated it was brought to her attention that one the medication cards was labeled wrong, so I initiated a plan of correction for it. She stated a medication prescription label on a narcotic card for Resident #11 regarding her oxycontin 5 mg was marked out / crossed out and someone wrote above 10 mg. She started education with all nurses on the controlled substance process. When asked DON to explain the process for removing controlled substance / narcotic medication from the medication carts once a resident was discharged from the facility, she explained that she goes to each unit every other week and checks the narcotics, removes the narcotic count sheet for that medication and the narcotic medication, reviews it with the nurse assigned to the cart that day and ensures the count is correct, her and the nurse sign off, then the narcotic medication is removed from that cart. She then scans the medication to the pharmacy. When the consultant comes into visit, we destroy the medication per protocol. She further stated that the nurses on the units are not allowed to remove any empty cards or discharged , discontinued medications from the medication carts due to a drug diversion that took place last year. When asked if she does this on a weekly basis, she stated she did. When asked explain why there was 92 medications cards on the carts on the 600 units with 50-60 of those medications belonging to residents who have been discharged from the facility over the last two months, she stated she had been out a few days. When asked to explain the process for when a narcotic count is not correct, she stated the nurse is to notify her immediately any time a count is not correct. Then she goes to that medication cart along with the nurses and attempts to figure out the discrepancy. She was not aware of any issues. She continues to state that nurses are not allowed to sign off narcotics for another nurse, that is against policy and regulations. When presented with an incorrect medication narcotic count sheet, she could not explain what happened. An interview with Staff Nurse B on 12/3/25 at 10:40 am was performed. She stated the facility process for administering narcotic medication: when you remove a narcotic medication to administer, you sign off on the narcotic medication count sheet and the administration record. When asked if she would ask a nurse to sign off a medication that was given and that she forgot to sign off, she replied that it is not allowed. Upon showing Nurse B a copy of the narcotic count sheet for Resident #11 and asked if she was familiar with Resident #11 and if she administered medications to Resident 11 on 12/1/25, she replied yes. Staff Nurse B looked at the narcotic sheet for Resident 11 and stated she gave her a pill at 09:00 am and stated, This is my signature here and points to the entry on 12/1/25 at 09:00 am. She further stated, I don't know whose signature that is below it. I know I gave her another pill that afternoon, but that is not my signature. Staff Nurse B then stated she did get a phone call yesterday from Staff Nurse C about a medication not being signed off. I told her to sign it off and I would come over the unit later on to sign and verify that I gave the medication. When asked if she went to the unit to verify later in the shift, she replied, no. An interview was conducted with Staff Nurse C on 12/3/25 at 4:00 pm. When asked if she recalls an issue</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based upon observations, policy review, and interviews the facility failed to maintain proper labeling of medications with dates of when medication was opened, correctly label multi-use vial medications of when it was first accessed, follow label instructions for expiration dates, and provide safe storage of controlled drugs. The findings include: An observation of medication carts was conducted on [DATE] at approximately 3:15 pm. Medication cart 1 on the 400 unit had loose tablets in the drawers, a medicine cup of a clear gel like substances with the name [NAME] written on it in the top drawer, and an expired insulin pen dated [DATE] with a label that states to throw away any remaining medicine that remains 28 days after the first use. (Photographic evidence obtained)The medication cart on the 500 unit reveals had loose pills in the top drawer, a medication cup with unknown tablets placed in the medication drawer with no label or identification of what the medication is. When asked, Nurse E stated she does not know what the medication the cup is. Expired insulin pens were observed on the medication cart. A vial of opened Haldol injection was in the top drawer that had been used but withno date on it. Multiple narcotic medication cards of residents who has been discharged from facility still on the medication cart.(Photographic evidence obtained)An observation was conducted of the medication cart on the 600 unit. This revealed a narcotic medication drawer was noted with approximately 92 cards with narcotic medications. When asked why there were so many, Nurse A responded that the cards on the right side of the drawer are for residents still in the facility. The cards on the left side and a few in the back of the right-hand side are narcotic cards of residents that were discharged over a month or two months ago. She stated they are not allowed to remove the cards from the medication cart per the directions of the Director of Nursing (DON). Loose tablets were noted in the top drawer of the cart. It was unknown what medications they were. The DON was asked to explain her process of removing medications from the medications carts once a resident is discharged from the facility and she states. She stated that she goes to each unit every other week and checks the narcotics, removes the narcotic count sheet for that medication, and the narcotic medication, reviews it with the nurse assigned to the cart that day and ensures the count is correct. They sign it off, then the narcotic medication is removed from that cart. She then scans the medication to pharmacy. When the consulted comes into visit, we destroyer the medication per protocol. She further states the nurses on the units are not allowed to remove any empty cards or discharged or discontinued medications from the medication carts due to a drug diversion that took place last year. When asked if she does this on a weekly basis she stated yes. When asked to explain why there was 92 medications cards on the carts on the 600 units with 50-60 of those medications belonging to residents who have been discharged from the facility over the last two months, she stated that she has been out a few days. Review of pharmacy consultant reports for the last 3 months on [DATE] shows no issues related to the medication carts upon inspection and no issues with controlled substances logs.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation and interviews, the facility failed to maintain all the areas in the kitchen in safe and functional condition. The findings include: On 12/02/2025 at 2:43PM, observation of the kitchen food cart storage area showed walls were damaged with scuffed marks, deep scratches, deep scrapes, and broken sheetrock. The east wall has a hole above the wood bumper about the size of a fist and above the base board approximately 3 feet long. The sheetrock has broken off, exposing sheetrock metal grate. The bottom of the main door appears to be damaged, causing the wood to split. Door frames were dirty with paint chipping off. The floor appears to be dirty, floor material chipping, exposing the concrete. The mop area floor tiles were missing and the drain is missing the floor drain cover. (Photographic evidence obtained) On 12/03/25, an interview with the Regional Dietary Manager revealed two forms were completed and given to administration for repairs. An evaluation was completed in October 31,2025 from the Registered Dietician stating that all floors and walls are not in good condition repairs is listed as pending. A quality assurance evaluation form completed on 11/13/25 by the Regional Dietary Manager was marked as unsatisfactory for floors, walls, and missing floor tiles in all food storage areas. On 12/03/2025 at 1:30PM, an interview with the Maintenance Director stated he was aware of the kitchen repairs and it has been approved and they have all the materials.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observations, staff and resident interviews, and record reviews, the facility failed to maintain an effective pest control program to ensure the facility is free of pests, specifically cockroaches. The findings include: Resident #6 On 12-2-25 at 12:07 pm, Resident #6 stated she has had cockroaches in her room. She stated her family purchased a glue pad because the facility is not doing anything about the problem. An observation of the floor under the air-conditioner (AC) revealed a glue pad that had several cockroaches and a very small roach running on the floor along side the glue pad. (Photographic evidence obtained) A second observation of the resident's room was conducted on 12-3-25 at 10:00 am and revealed the glue pad contained many more dead roaches and some still alive attempting to free themselves. On 12-5-25 at 11:19 am interview was conducted with the Maintenance Director, who stated he recently had the pest control change from spray to dust in order to address the ongoing roach problem. He also stated they bought the glue strips and placed them in resident rooms under the AC unit. When asked why there are so many live roaches, he did not have an explanation. At this time, he confirmed the pest control has not been effective. The pest control invoices revealed monthly services occurred on site two times per month for resident rooms. Monthly service was performed for common areas, kitchens/dining areas, housekeeping/laundry, activity/therapy rooms, dry food storage, courtyard, dumpster area, and the perimeter. Review of Pest Sighting Logs for the 400/500/600 halls revealed numerous recent sightings of roaches on 400, 500 and 600 halls between 7-15-25 and 11-21-25. Review of the Pest Sighting Logs for the 100/200/300 halls revealed numerous sightings of roaches as recently as 12-2-25 on the 200 and 300 halls.</p>		