STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. Building B. Wing	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at St Cloud	4641 Old Canoe Creek Road Saint Cloud, FL 34769

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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

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

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F 0610 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 interview, and record review, the facility failed to ensure staff reported allegations of abuse timely and thoroughly investigate an alleged incident of sexual abuse by a cognitively impaired male resident, (#2), resulting in a delay of implementation of appropriate corrective actions, based on the result of the investigation findings.Findings:Review of resident #1's medical record revealed she was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease with late onset, schizoaffective disorder bipolar type, mood disorder, disorder of psychological development, and attention-deficit hyperactivity disorder.Review of resident #1's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had clear speech, was able to be understood, and could understand others. Her Brief Interview of Mental Status (BIMS) score was 10 out of 15, which indicated moderate cognitive impairment.Resident #2's record revealed he was admitted to the facility on [DATE] with diagnoses that included dementia, alcohol abuse with alcohol-induced psychotic disorder, and primary insomnia.The quarterly MDS assessment for resident #2 dated 7/29/25 revealed he had clear speech, was able to be understood, and was able to understand others. His BIMS score was 6 out of 15, which indicated severe cognitive impairment.Review of resident #2's medical record revealed he had a care plan initiated on 6/02/14 for the use of psychotropic medications related to behavior management. The care plan was initiated on 6/01/24 and was revised on 10/17/24.On 10/09/25 at 1:40 PM, resident #1 was in her room sitting in a chair by the window next to her bed. She expressed she was fearful but was willing to speak about the incident on 10/06/25. The resident explained that night around 9:00 PM, she was asleep in her bed when she was awakened by resident #2 touching her back, arm, and stomach. She recalled she immediately screamed and resident #2 exited the room. Resident #1 said she walked out of her room and saw resident #3 in the hallway who told her he heard her scream. She asked resident #3 to tell the nurse. Resident #1 conveyed the nurse came to see her and asked her what happened but did nothing else in regard to ensuring resident #2 did not repeat his actions. Resident #1 reported she could not sleep well that night because she was scared that resident #2 would come back to the room. She said she called her sister that night and told her what had happened, and, in the morning, she saw resident #2 still wandering in the hallway.On 10/09/25 at 1:29 PM, resident #3 stated that on 10/06/25 at approximately 9:00 PM, he was in his room, sitting in his wheelchair and had a clear view of the hallway. He recalled he saw resident #2 walking down the hallway towards resident #1's room and moments later heard her scream. He went towards resident #1's room and she was coming out of the room. She seemed scared and told him that resident #2 had come into the room and touched her while she was asleep. Resident #3 said she asked him to tell the nurse because she was scared to do it herself. Resident #3 said he spoke with Licensed Practical Nurse (LPN) B at the nurses' station and told him what he had witnessed. He remembered resident #1 joined them a few moments later at the nurses' station and told LPN B what happened. Resident #3 said LPN B took resident #1 back to her room and attempted to calm her down but he did not recall anything was done to keep resident #2 from returning to resident #1's room. He said he had witnessed at other times, resident #2 entering other resident rooms uninvited and touching their belongings. He explained that resident #2 used to be his roommate and he requested to change rooms because he used to touch his things without permission. He said he felt resident #1 was affected by the incident because she was scared to sleep that night and was crying.On 10/09/25 at 1:29 PM, resident #3 was sitting in the common area of the facility. He could not recall the event nor any details of what happened.On 10/10/25 at 12:14 PM, LPN B confirmed he had worked on 10/06/25 during the overnight 7:00 PM to 7:00 AM shift. He said that between the hours of 11:00 PM and 11:30 PM he was in the 100-hallway where residents #1, #2, and #3 lived, passing medications alongside LPN A. The LPN recalled that residents #1 and #3 walked casually down the hallway to LPN A and reported that resident #2 had entered resident #1's room to touch her but they did not say where she was touched. LPN A told resident #1 to go back to her room and she would come see her. LPN B said he did not see resident #2 in the hallway at that time, which he indicated was rare because he usually paced the hallways at night. LPN B said he was not resident #1 or #2's nurse, so he was not involved and did not report the incident to the on-call Supervisor. The nurse said he was not asked to write a statement by anyone at the facility.On 10/10/25 at 11:52 AM, LPN A confirmed she was the assigned nurse for residents #1 and #2 on 10/06/25. She said that between the hours of 10:30 PM and 11:00 PM, she passed medications in the 100-hallway when resident #1 walked up to her cart and was visibly