

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Aviata at Sarasota		STREET ADDRESS, CITY, STATE, ZIP CODE 1507 S Tuttle Ave Sarasota, FL 34239	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews, the facility failed to ensure 1, (Resident #2), of 3 residents with admitting facility orders for an antibiotic medication were clarified by the residents' primary care physician. The findings included: Review of the facility's Medication Reconciliation policy #N-1590, with an effective date of 12/17/24, stated the medication reconciliation is the process of ensuring accurate and complete medication list during a transition in care. The medication reconciliation occurs during admission/re-admission and discharge. The policy noted to review and compare medications from the most recent hospital stay, home or prior living establishment and prior stay in the facility; review medication dosage, frequency, and stop date; review all discrepancies with the physician and document findings on the Medication Reconciliation in the resident's medical record. Review of Resident #2's medical record revealed she was admitted to the facility on [DATE] with diagnoses that included Septic Arterial Embolism, Bacteremia, and Methicillin Susceptible Staphylococcus Aureus Infection. A medication error form dated 8/15/25 at 11:00 a.m. stated Resident #2 had missed doses of IV ABT (Intravenous Antibiotic Therapy) on 8/14/25 at 6:00 p.m. and 10:00 p.m., and on 8/15/25 at 2:00 a.m., 6:00 a.m., and 2:00 p.m. The doctor was made aware and IV ABT ordered and verified they were on the way from the pharmacy. Infectious disease specialist was notified and informed the resident had missed doses. The infectious disease specialist gave the okay to start the IV ABT upon arrival. Review of the facility incident report and investigation noted Resident #2 was admitted to the facility on [DATE] with admitting physician orders. On 8/15/25 the nursing staff identified Resident #2 had not received prescribed IV ABT of Oxacillin 2 grams every 4 hours that were ordered on admission. The nursing staff identified the missed doses and the IV ABT medication was ordered from pharmacy and arrived on 8/15/25 and administered as per the physician orders. The facility investigation noted Resident #2 had missed 5 doses of the IV ABT. Resident #2's admitting nurse, Staff C, said the Unit Manager was responsible for the admission and order transcription. Review of the Discharge Reconciliation Document noted the Unit Manager Staff B had placed a question mark next to the Oxacillin order on the hospital medication Discharge Reconciliation Document indicating the medication needed to be clarified by the physician. On 12/2/25 at approximately 2:15 p.m., the Director of Nursing (DON) and the Executive Director (ED) confirmed Resident #2 had missed 5 doses of Oxacillin 2 grams IV ABT when she was admitted to the facility on [DATE]. The DON said every morning she reviewed all new admissions to the facility from the prior day, and she noted a question mark next to the Oxacillin order on Resident #2's Discharge Reconciliation Document from the hospital. The DON said when she reviewed Resident #2's MAR (Medication Administration Record), she noted the Oxacillin was not listed as administered. She then investigated and determined the Unit Manager had not clarified the Oxacillin medication listed on the discharge reconciliation form as required. This caused the medication not to be ordered and administered. She notified the primary care physician and the hospital infectious disease specialist and received the required clarification orders which she sent to pharmacy. The medication arrived that afternoon and was administered at that time. On 12/3/25 at around 10:00 a.m., Staff C confirmed she was Resident #2's nurse when she arrived at the facility. She said because she was busy, the Unit Manager said she would complete Resident #2's admitting paperwork. She said when she was done with her work, she assisted the Unit Manager to complete Resident #2's admission paperwork, and she noted the Oxacillin medication on the discharge orders did not have a dose, frequency or route. They tried to text the primary care physician for clarification order for the Oxacillin, but he did not text her back or call. She said the Unit Manager told her to go home and she would get the clarification order for the Oxacillin. She said she was unaware the Oxacillin was not clarified by the Unit Manager as required until the DON called her to ask why they had not clarified the Oxacillin medication order during Resident #2's admission to the facility on 8/14/25.</p>		

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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. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and record review the facility failed to ensure 1, (Resident #1), of 3 residents reviewed for accidents was not burned by hot coffee. The facility had not provided the required staff education and equipment to ensure the reheating of residents' food or beverages were served at an appropriate safe temperature. The findings included: On 12/1/25 a review of an adverse incident report revealed upon completion, Resident #1 had spilled hot coffee on his lap on 9/23/25 causing a blister to the right upper thigh area. On 12/1/25 a review of Resident #1's medical record revealed he was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following a cerebral infarction, muscle wasting and atrophy. A nursing progress note dated 9/24/25 at 6:43 p.m., stated the writer was informed by CNA (Certified Nursing Assistant), Staff A, Resident #1 had spilled coffee on his lap. Upon assessment of the skin, the writer noted one small, blistered area on the upper right thigh near his groin, the skin is not intact, and the dermal layer is absent on the upper thigh. The resident did not complain of pain and the primary care physician and family were notified. Wound care to follow up on 9/25/25. An ARNP (Advance Registered Nurse Practitioner) wrote on 9/27/25 at 1:10 p.m. The patient is seen today for a follow-up on the burn area on his right thigh that happened on 9/25/25 after he accidentally spilled coffee on it. Silvadene cream was applied to the affected area, pending the Wound Care team to evaluate the site. Advised to keep the area clean and dry. Monitor for secondary skin infection, such as increasing erythema, discharge, pain, swelling and fever. On 10/9/25 a Wound Assessment Report noted a right thigh 1st degree burn with partial thickness measuring 7.0 cm (centimeters) by 2.50 cm with a depth of 0.1 cm. Facility to cleanse the area with normal saline daily and as needed, apply Silver Sulfadiazine 1% cream and leave open to air. On 12/1/25 at around 11:50 a.m., in an interview with Resident #1, he said on 9/23/25, he had returned to his room and went to his room door to ask someone to reheat his coffee. He saw the DPO in the hallway and he asked him to reheat his coffee. The DPO went to the nurses' station and came back with his reheated coffee. He then asked Staff A for some sugar, and when she handed him the sugar, he spilled his coffee on his lap causing the burn to his upper right thigh area. He said the area is now healed and he did not feel any pain at the time of the incident. Review of the facility's Re-heating Resident Food and Beverages policy D-306 with an effective date 11/30/2024, stated this policy is to reduce the risk of resident burns related to hot beverages, liquids and food, and to provide guidance on re-heating resident food and/or liquids. Staff members are to reheat residents' food and or liquids in the microwave to the temperatures that are safe and palatable for residents. Under the procedure section it states . The staff member is to use the dial thermometer provided to ensure a maximum temperature of the item is not greater than 140 degrees at the time of service. On 12/2/25 at 9:15 a.m., CNA Staff A said she was hired 7/1/25. She said on 9/23/25 when she handed Resident #1 the sugar for his coffee, he accidentally spilled it onto his lap. She said she was unaware the coffee had burned Resident #1's upper right thigh until he told her on 9/24/25, and that is when she told the nurse. She said several weeks later she had learned that someone had reheated Resident #1's coffee prior to him spilling it on his lap. She said the facility did education with all the staff about the facility's Re-heating Resident Food and Beverages policy and now the policy is posted by the microwave machine along with a thermometer to check the food or beverage prior to giving the reheated food/beverage to the resident. She said prior to facility wide in-service about the Re-heating Resident Food and Beverages policy she was unaware they were required to check the food or beverage temperature prior to handing a resident reheated food or beverage. On 12/2/25 at 9:40 a.m., the DPO said he had been working at the facility for 1.5 years. He said on 9/23/25 he was walking down the hallway when Resident #1 asked him to reheat his coffee. He said he brought the coffee to microwave, pressed the start button once, reheated Resident #1's coffee, gave Resident #1 the reheated coffee and left the area. He said it was not until several weeks later, when the Executive Director (ED) asked him if he had reheated Resident #1's coffee on 9/23/25 that he learned Resident #1 spilled the coffee in his lap causing a burn to his upper thigh area. He said the ED conducted a 1:1 education with him related to the facility's Re-heating Resident Food and Beverages policy. He said until he received the 1:1 education with the ED on 10/30/25, he was unaware of the facility Re-heating Resident Food and Beverages policy. He said the policy is now posted next to all the microwaves in the facility along with a thermometer to check the reheated food or beverage to ensure it is below 140 degrees before giving it to the resident. On 12/2/25 at approximately 11:00 a.m. the Director of Nursing</p>		