STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106032	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Sarasota	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of facility policy, and clinical record review, the facility failed to immediately inform the resident representative when there was a significant change in the resident's physical status and decision to transfer the resident to the hospital for 1 (Resident #1) of 3 residents sampled.The findings included:Review of facility policy and procedure N-105 effective [DATE], revised [DATE], Notification of Change in Condition revealed Policy: The center to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is a change in the status or condition. Procedure: The nurse to notify the attending physician and Resident Representative when there is a(n): Accident, Significant change in the patient/resident's physical, mental, or psychosocial status, Need to alter treatment significantly due to but not limited: Adverse consequences, Acute condition, Exacerbation of chronic condition, A transfer or discharge of the Patient/Resident from the Center. In the event of an emergency situation, 911 to be called and the attending physician and the Resident Representative to be notified as soon as possible . Document the notification in the medical record.A review of the clinical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of surgical aftercare following surgery on the digestive system, disruption or dehiscence of closure of internal operation (surgical) wound (a surgical incision unexpectedly breaks open during the healing process), presence of cardiac and vascular implant and graft (a history of heart and blood vessel surgery), and presence of aortocoronary bypass graft (a history of heart blood vessel surgery).Review of the Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) dated [DATE] revealed Resident #1 had normal cognitive functioning. He required supervision or touching assistance for transfers, sit-to-stand, and walking up to 50 feet.Review of the clinical record for Resident #1 revealed a Progress Note [DATE] at 9:30 p.m. documented Resident #1 complained of not feeling well, patient stated that he hasn't felt well in a couple of days now and keeps having bowel movements. He said he didn't even feel well enough to go out to smoke his cigarettes today. The progress note documented Staff B Licensed Practical Nurse (LPN) went to her medication cart to check his orders for anything for GI (Gastointestinal) upset and moments after a Certified Nursing Assistant (CNA) alerted her to go to him quickly. Upon entering the patient's room he was seen sitting on the toilet hunched over and was being held up by the other CNA. Staff B LPN called a Code Blue (emergency situation), called 911 and Resident #1 was transferred to the hospital.Review of the clinical record for Resident #1 revealed a Change in Condition assessment dated [DATE] at 12:22 a.m. The Change in Condition documented in the evaluation was Unresponsiveness. The Change in Condition Assessment did not document the family representative was notified. This section was left blank.Review of the clinical record for Resident #1 revealed a Transfer Assessment was initiated on [DATE], but it was blank.Review of the clinical record revealed there was no documentation that Resident #1's representative was (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified of his change in condition or transfer.On [DATE] at 3:07 p.m. in an interview, the DON (Director of Nursing) said she called the hospital on [DATE] around 5:30 or 6:00 a.m. for an update on Resident #1. She said she heard the resident had multiple cardiac events overnight and was alive. She said after she received that update, early in the morning on [DATE] the nephew of Resident #1 (the resident's representative) called to ask what had happened at the facility. She said the resident's representative told her the hospital had called him in the middle of the night to inform him that the resident was in the Emergency Room. She said she told Resident #1's representative that an aide had answered the resident's call light and he was not looking good. She said she told him the aide got the nurse and EMS was called. She said she told him it seemed like a vaso-vagal event (fainting due to nerve stimulation).The DON said the Change in Condition Assessment in Resident #1's clinical record does not indicate that the Emergency Contact was notified. She said best practice is that the facility notify the family or Emergency Contact of a change in condition. She said she thought that maybe the Staff A LPN Unit Manager's signature on the Agency for Healthcare Administration (AHCA) form indicated that she had informed the resident's representative of the change in condition and transfer.On [DATE] at 3:54 p.m. in an interview, Staff A LPN Unit Manager said she came to work at the facility in the morning on [DATE]. She said at approximately 9:00 a.m. she spoke to Resident #1's representative and let him know the resident was coded (had cardiopulmonary resuscitation, also known as CPR) and sent to the hospital. She said she did not document after speaking to the resident representative on [DATE].

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of facility policies, the facility failed to report an allegation of neglect that resulted in death within the specified required timeframe for one resident (Resident #1) reviewed.The findings included:Review of facility policy N-1265 effective 11/30/2014, revised 11/16/2022 Abuse, Neglect, Exploitation & Misappropriation revealed Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations.Review of facility investigation revealed on 12/26/25 at approximately 8:03 p.m. in a phone conversation with the Director of Nursing (DON) and the Administrator Resident #1's representative stated he felt Resident #1 should have been transferred to the hospital sooner. The investigation documented that the Administrator became aware of the situation on 12/26/25 at 8:03 p.m. The report of this allegation of neglect was submitted to the Agency on 12/27/25 at 3:29 p.m.On 1/14/26 at 3:07p.m. in an interview, the DON said that Resident #1 was transferred to the hospital on [DATE]. She said she spoke to the resident's representative the morning of 12/26/25 and he informed her that the resident had passed away. She said later in the day the representative was asking more questions about what happened at the facility before Resident #1 was sent to the hospital. She included the Administrator on a 3-way phone call with the representative on 12/26/25 and the representative said he thought they should have sent the resident to the hospital sooner. The DON said she felt it was an allegation of neglect. She acknowledged that the allegation was not reported to the Agency until 12/27/25 at 3:29 p.m. She said the delay may have been because she and the Administrator were trying to gather more information. She said they were trying to see if there was anything they'd have to add to the report before they submitted it.