STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105257	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Saint Lucie	611 S 13th St Fort Pierce, FL 34950

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care and services for showers, as evidenced by failing to provide documented evidence for proof of showering for 1 of 3 sampled residents who were reviewed for shower service, (Resident # 4).The findings included: Clinical record review documented Resident #4 was admitted to the facility on [DATE], with a diagnosis of cancer. Review of the quarterly Minimum Data Set (MDS) assessment dated on May 18, 2025, included a Brief Interview for Mental Status (BIMS) with a score of 15, indicating the resident was cognitively intact. This MDS assessment recorded no mood or behavioral issues. It was noted in the MDS that Resident #4 experienced functional limitations in range of motion due to impairments in one side of both the upper and lower extremities. He required substantial to maximal assistance with showering, bathing, upper and lower body dressing, and personal hygiene, and was dependent on staff to put on and remove his footwear. The MDS revealed that the mobile device used by Resident #4 was a wheelchair.Review of the Certified Nursing Assistant (CNA) tasks in the computer recorded his shower schedule: shower on Monday, Wednesday, and Friday during the 7 AM to 3 PM shift. Further review of the CNA tasks over the last 30 days revealed no documented evidence of showers on the following dates: June 30, 2025, July 2, 2025, July 7, 2025, July 11, 2025, July 14, 2025, and July 16, 2025.During an interview on July 29, 2025, at 12:38 PM, Resident #4 was asked if he had received showers. He responded, Never. He shook his head no when asked if he had ever had a shower at the facility. When asked if he refused showers when scheduled, he said, No, they tell me maybe later, but it doesn't happen. When asked if he received a bed bath, he replied, Pretty much. When asked again if he had received any showers since admission, he reiterated, No, never.On July 29, 2025, at 12:55 PM, Staff F, CNA, who has worked at the facility for 26 years, was interviewed. She stated Resident #4 was scheduled for showers three times a week, and that any received showers or refusals should be recorded in the shower books. Reviewing the shower books with Staff F revealed no documented showers or refusals for Resident #4.On July 29, 2025, at 2:04 PM, a side-by-side review of Resident #4's records, including the shower books, was conducted with an interview with the Interim Director of Nursing (DON). He confirmed the absence of documented showers or refusals.

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
	105257	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Saint Lucie	611 S 13th St Fort Pierce, FL 34950

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 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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105257	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Saint Lucie	611 S 13th St Fort Pierce, FL 34950

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 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 interviews and records review, the facility failed to ensure pain medication was administered as ordered by the physician, as evidenced by failure to ensure pain medication was documented as administered, nurse refusal to provide pain medication and failure to provide documented evidence of appropriate training and education to the nurses following the incident for 1 of 3 sampled residents reviewed, (Resident # 5).The findings included: Review of the clinical record revealed Resident #5 was admitted to the facility on [DATE], with a diagnosis that included depression. Review of the quarterly Minimum Data Set (MDS), with a reference date of June 25, 2025, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #5 was cognitively intact. The MDS documented mood symptoms, including feelings of being down, depressed, or hopeless, and no exhibited behaviors were recorded. The MDS documented Resident #5's pain level as an eight on a scale of 1 to 10. Review of the physician's order from December 18, 2024, documented an order for the administration of one Percocet oral tablet (10-325 mg) every six hours as needed for pain. The care plan, revised on July 15, 2025, indicated that Resident #5 experienced potential pain related to the disease process, including back pain and neuropathy. As part of the intervention, analgesics were to be administered as prescribed. The care plan also noted the presence of a venous/stasis ulcer on the left posterior leg, left medial leg, and left foot, with the intervention to provide medications as ordered for pain. On July 28, 2025, at 2:35 PM, during an interview with Resident #5, he expressed a need for pain medication, and the nurse refused his request, suggesting that he intended to hide his Percocet and give it to his girlfriend, Resident #2. He stated he didn't receive his as-needed Percocet until the next day, and he was in pain. He revealed that the situation escalated as the nurse argued with him. During this interview process, Resident #2, who was in the room, reported hearing the nurse argue with Resident #5 and denying him pain medication. On July 28, 2025, at 1:59 PM, a phone interview was conducted with Staff A, Registered Nurse (RN). When asked about the incident, she claimed that Residents #2 and #5 frequently spent time together. They left the facility and returned heavily sedated, stating they couldn't even hold their bodies up. She alleged that Resident #2 encouraged Resident #5 to request Percocet. Staff A mentioned that she offered Resident #5 two Tylenol instead and planned to reassess the need for the stronger pain medication (Percocet) later. She noted that residents sometimes hide pain medication in their mouths to sell it to others. Record review revealed that Resident #5 did not have Tylenol ordered. In a statement by Staff B, the activity assistant, she indicated that on Monday, June 16, 2025, at approximately 5:45 PM, she witnessed Staff A refuse to provide Resident #5 with his pain medication, documenting concerns that he intended to give it to Resident #2. The facility's investigation revealed no documented evidence of appropriate training and education with the nurses following the incident. While training was conducted on June 8, 2025, before the incident, it focused on policies regarding reporting abuse, neglect, and exploitation. There was no documented training specific to pain management and medication administration following the incident. On July 29, 2025, at 1:43 PM, an interview was held with the Nursing Home Administrator (NHA) regarding the absence of documented training/education on pain management and medication administration for the nursing staff after the incident. The NHA mentioned that the former interim Director of Nursing (DON) might have conducted this training, possibly storing it in the Assistant Director of Nursing's (ADON) office. The NHA left to search for the training documentation and returned with an in-service sheet indicating education on medication errors, signed by nurses, dated April 9, April 15, and April 16. This training was not specific to the incident involving the nurse's refusal to administer pain medication, nor did it address pain management or medication administration. On July 29, 2025, at 1:45 PM, a phone interview was conducted with Staff C, the former interim DON. She revealed that she was present during the incident and was instructed to educate the staff on abuse, neglect, exploitation, and misappropriation while gathering statements. She did not provide training or education specifically on pain management or medication administration. Continuing the interview with her was challenging due to background noise. Later, at 2:08 PM, Staff C called the surveyor back and stated she had initiated education on abuse and neglect and passed this training on to the former ADON. On July 29, 2025, at 4:16 PM, an interview was conducted with Staff D, Registered Nurse (RN) employed at the facility since May 2025. She mentioned that training had been provided on documentation related to dialysis, call lights, and biohazard procedures. When asked about training on medication administration and pain management, she stated that she had only received