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	04/14/2026

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 clinical and administrative record review and interview, the facility failed to ensure that residents receive the necessary treatment and care in accordance with professional standards of practice. This is evidenced by the facility failing to follow the prescribed monitoring, administration and accurate documentation for 2 of 6 sampled residents (Resident #1 and Resident #2). The findings included:1) Review of the clinical record for Resident # 1 revealed that the resident was admitted to the facility on [DATE] with pertinent diagnosis of prosthetic heart valve. Further review of the physician orders revealed that the physician prescribed on 02/06/26 Warfarin Sodium (anti-coagulant) 5 mg by mouth every other day for valve replacement to begin on 02/07/26 and she prescribed for labs for warfarin (PT/INR), CBC with diff and comprehensive metabolic panel (CMP). However, the 02/07/26 labs drawn for PT/INR are noted as invalid. Then on 02/07/26 at 5:23 PM, the physician prescribed to hold Warfarin pending PT/INR results. On 02/08/26, the nurse noted that the results of the PT/INR were received and the physician was contacted. The physician prescribed for the resident to receive Warfarin 2.5 mg on 02/08/26 and to resume Warfarin 5.0 mg daily on 02/09/26. Review of the Medication Administration record for Resident # 1 revealed that the nurses placed their initials in the appropriate boxes to indicate that the Warfarin 2.5 mg was administered on 02/08/26 and Warfarin 5.0 mg was administered on 02/09/26, 02/10/26 and 02/11/26. Further review of the physician orders revealed that the warfarin 5 mg was placed on hold 02/07/26 to 02/10/26 and 02/13 to 02/16/26. However, the nurse documented that the resident's INR was 3.38 on 02/09 and 02/10/26. Additionally, the 02/11/26 warfarin 5.0 mg was administered, the nurse documented the INR was 9.12, yet the nurse still administered the medication despite the INR being elevated. Also, there is no evidence that the nurse contacted the physician when the resident's INR were elevated for guidance regarding administration of the warfarin.On 02/13/26 when the INR was noted as critically elevated at 17.63, the physician prescribed for the resident to received Vitamin K 10 mg intramuscular injection and to have the PT/INR labs done for 2 days. Further review of the lab results failed to provide evidence that the labs were drawn and there is no evidence that the staff followed up with the lab to ensure the physician order was followed. Labs were not completed until 02/16/26. However, by this time, the resident was noted to have a change in condition, in which her condition deteriorated becoming nonresponsive and not eating, requiring additional intervention and eventual transfer to the hospital for further evaluation on 02/16/26. Review of the Medication Administration Record (MAR) revealed multiple entries for Warfarin Sodium Oral Tablet 5 MG on 02/07/26, 02/09/26, and 02/12/26: Warfarin 2.5 mg on 02/08/26.An interview was conducted on 04/14/26 at 2:30 PM with the Director of Nursing, who confirmed the labs were not drawn on 02/14/26 and 02/15/26. The labs were not drawn until 02/16/26. She further confirmed there is no evidence that the nurses contacted the physician before noting they administered the warfarin when the resident's INR was elevated. She stated that the evening supervisor did contact the physician, when she noted that the nurse administered the warfarin on 02/11/26 when the INR was 9.12. That nurse no longer works for the facility, and the other nurses also are unavailable or no longer work for the facility.Further review of the pharmacy records for Resident # 1. According to the dispensary records for Resident # 1, the pharmacy records (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted that warfarin 5 mg dispensed 7 tablet three times for a total of 21 tablets of Warfarin 5 mg. However, 20 tablets were returned to the pharmacy upon the resident's discharge. Please note, that the nurse placed their initials on 4 doses of administered doses of Warfarin: Warfarin 2.5 mg once and Warfarin 5 mg three times.Further inquiry was made with the Director of Nursing on 04/14/26 in the afternoon, who reported that despite the facility having an Emergency Drug kit, no Warfarin tablets were removed from the E-Kit (emergency kit), and the facility did not have any other residents on Warfarin and have not had any residents on Warfarin in over a year. 2) An observation of medication administration for Resident # 2 was conducted on 04/14/26 beginning at approximately 5:45 PM with the Licensed Nurse, Staff A. The nurse prepared the resident's medication and the surveyor verified with the nurse the 6 pills (Acidophilus 1 capsule, carvedilol 6.25 mg, docusate sodium 100mg, metformin HCL 1000 mg, Topamax 25 mg and Trazadone 50 mg). The nurse administered the 6 pills. The surveyor confirmed with the nurse, the resident did not have any additional medication to be given other than the Lantus, which was held because the resident's blood sugar was 109. However, upon medication reconciliation, the nurse documented on the medication administration record that she also had administered polyethylene Glycol 3350 powder, give 17 GM by mouth twice daily for constipation. Mix with 8 ounces of fluid. This medication was not administered during the observed medication administration.An interview was conducted with Staff A on 04/14/26 at approximately 6:30 PM, regarding her signing that she administered the polyethylene. She confirmed she had not administered the medication but signed that she had administered it. The nurse then proceeded to go through the medication cart to retrieve the medication and noted that there wasn't any on the cart. She then went to supply room and retrieved the bottle and administered the prescribed order. The surveyor further questioned the nurse regarding her administering the medication because the resident is prescribed this medication twice daily. She stated she must have retrieved the medication from the other cart, when she administered the medication this morning, since none was available on this cart.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical and administrative record review and interview, the facility failed to ensure the staff take appropriate action (e.g., suspending administration of the anticoagulant) in response to an elevated International Normalized Ratio (INR) for a resident who is receiving warfarin, resulting in the future hospitalization of the resident. The staff failed to respond appropriately to an INR level that is above the target range for treatment. The staff failed to ensure the prescribed laboratory monitoring was conducted and/or provided evidence that follow-up is performed when not done. This failure affected 1 of 1 resident prescribed warfarin therapy (Resident # 1).The findings included:Review of the clinical record for Resident # 1 revealed the resident was admitted to the facility on [DATE] with a diagnosis of prosthetic heart valve. The physician prescribed for the resident to receive warfarin 5 mg and to have PT/INR monitoring.Further review of the results of PT/INR (Prothrombin/International Normalized Ratio) for Resident # 1 revealed the following:The 02/07/26 labs drawn for PT/INR are noted as invalid. On 02/11/26 the PT/INR revealed a PROTHROMBIN TIME 94.9 SECS (normal range 9.6 - 12.6) and an INR of 9.12 RATIO (normal range - 0.87 - 1.13). On 02/13/26 the PT/INR revealed a PROTHROMBIN TIME 180.0 SECS and an INR of 17.63 RATIO.The physician also prescribed on 02/13/26 for the resident to have additional PT/INR lab test completed for 2 days on Saturday, 02/14/26 and Sunday 02/15/26, however they were not done. The PT/INR was not done until Monday, 2/16/26. At this time the resident was noted to have a change in condition and the resident was nonresponsive and not eating. The Advanced Registered Nurse Practitioner documented a progress note on 02/16/26 which documented a prosthetic heart valve, presented with lethargy today. Her history includes lupus, rheumatoid arthritis, hypertension, and recurrent bronchitis. She was found to have a critically elevated INR of 17.63 and PT 180 2/13/26. Warfarin was held, and Vitamin K was administered. Labs completed this am INR/PT pending results. Will continue to monitor closely. The note further documented an Assessment: Dehydration requiring intravenous fluid replacement. Plan: Sodium chloride 75 ml intravenous for dehydrationA Psychiatric practitioner noted on 02/16/26, Patient is lying in bed awake but is drowsy and lethargic. Patient is less responsive to provider. Patient is being followed up by primary care nurse practitioner. Primary nurse reports decline as patient is not eating as before and patient exhibits an overall decline. Symptoms of anxiety and depression are well controlled. Patient has no behavioral outbursts.The Director of Nursing documented a progress note on 02/16/26 at 5:00 PM, Writer met with resident's son, husband and sister-in-law at bedside to discuss current POC. Warfarin management discussed and they were informed of medication error related to it. They verbalized understanding of same and all questions addressed. Resident currently lethargic and non-verbal which was discussed with family and ARNP. Initial phone orders received to have STAT CBC, CMP, CXR and EKG vs hospital transfer but family opted in for transferring to hospital. Resident peri-care provided prior to transfer and assigned nurse called in report. Last labs sent with resident for hospital referral. Resident 0.9% NS IVF disconnected prior to transfer. Skin assessment completed and no open areas noted at this time.Prior to the resident's change in condition on 02/16/26, the physician prescribed on 02/06/26 for the resident to receive Warfarin Sodium 5 mg by mouth every other day beginning 02/07/26. The physician also prescribed for PT/INR lab to be drawn. Then on 02/07/26 at 5:23 PM, the physician prescribed to hold Warfarin pending PT/INR results. On 02/08/26, the nurse noted that the results of the PT/INR were received and the physician was contacted. The physician prescribed for the resident to receive Warfarin 2.5 mg on 02/08/26 and to resume Warfarin 5.0 mg daily on 02/09/26. Review of the Medication Administration record for Resident # 1 revealed that the nurses placed their initials in the appropriate box to indicate that the Warfarin 2.5 mg was administered on 02/08/26 and Warfarin 5.0 mg was administered on 02/09/26, 02/10/26 and 02/11/26. Further review of the physician orders revealed that the warfarin 5 mg was placed on hold 02/07/26 to 02/10/26 and 02/13 to 02/16/26. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse documented that she administered this medication on 02/08/26. The warfarin 5.0 mg administered on 02/09/26 and 02/10/26, the nurse documented that the resident's INR was 3.38. Additionally, the 02/11/26 warfarin 5.0 mg administered, the nurse documented the INR as 9.12, yet the nurse still administered the medication despite the INR being elevated. Also, there is no evidence that the nurse contacted the physician when the resident's INR were elevated to gain guidance prior to the administration of the warfarin.On 02/13/26 the physician was contacted when the INR was again noted as critically elevated at 17.63, the physician prescribed for the resident to received Vitamin K 10 mg intramuscularly injection and to have the PT/INR labs done for 2 days. Further review of the lab results failed to provide evidence that the labs were drawn and there is no evidence that the staff followed up with lab to ensure the physician order was followed. Labs were not completed until 02/16/26. However, by this time, the resident's condition has changed and deteriorated, requiring additional intervention and eventual transfer to the hospital for further evaluation on 02/16/26. An interview was conducted on 04/14/26 at 2:30 PM with the Director of Nursing, who confirmed the labs were not drawn on 02/14/26 and 02/15/26. The labs were not drawn until 02/16/26. She further confirmed there is no evidence that the nurses contacted the physician before noting they administered the warfarin when the resident's INR was elevated. She stated that the evening supervisor did contact the physician, when she noted that the nurse administered the warfarin on 02/11/26 when the INR was 9.12. That nurse no longer works for the facility, and the other nurses also are unavailable or no longer work for the facility.