STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105588	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Santa Barbara	216 Santa Barbara Blvd Cape Coral, FL 33991

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 - Some	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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review and interview, the facility failed to ensure 3 (Residents #1, #2 and #3) of 3 residents reviewed received care and services in accordance with professional standards of practice by failing to ensure laboratory testing were done as ordered for Residents #1, #2, and #3. The facility failed to document family reported concerns and failed to notify the practitioner of several episodes of loose stools for Resident #1.The findings included:Resident #1:Review of the facility's policy and procedure titled, Laboratory, Diagnostic and X-Ray with a revision date of 02/02/2024 revealed, Procedure: Obtain a physician's order for laboratory work, diagnostic testing, and x-ray. Complete the required requisition form(s). Schedule laboratory work, diagnostic test and or x-ray as indicated.Review of the clinical record for Resident #1 revealed an admission date of 6/12/25.Review of the progress notes revealed on 7/5/25 the Advanced Practice Registered Nurse (APRN) documented Resident #1 was evaluated for persistent bilateral leg edema (swelling) and shortness of breath. Lungs with bilateral rhonchi and wheezing (abnormal breath sounds). The practitioner documented a CMP (Complete metabolic panel) and Pro-BNP (measures a specific protein) were ordered to monitor electrolytes and volume status. The plan of care was discussed with the nurse. The progress note documented next labs pending were comprehensive panel, CBC (complete blood count) and Pro-BNP.Review of the Treatment Administration Record (TAR) for July 2025 revealed on 7/7/25, the Licensed Nurse placed her initials, indicating Resident #1's blood was drawn for the CMP, CBC and Pro-BNP.On 7/8/25 the APRN documented in a progress note Resident #1 complained of dysuria (painful urination). A urinalysis revealed a urinary tract infection. The practitioner ordered an antibiotic. The progress note documented the nursing staff reported that the resident had a foul smelling vaginal discharge consistent with suspected bacterial vaginosis (vaginal infection). The resident was started on empiric antibiotic treatment. The APRN documented the laboratory tests were currently pending results to monitor kidney function and electrolytes. On 8/4/25 review of the clinical record for Resident #1 failed to reveal results for the CBC, BMP and Pro-BNP the licensed nurse signed as obtained on 7/7/25.On 8/4/25 at 2:50 p.m., in an interview the Director of Nursing (DON) and Regional Nurse verified the lack of results for the CBC, BMP and Pro-BNP the APRN ordered on 7/5/25. They said they were not aware the resident's blood was never drawn.Further review of the progress notes revealed on 6/14/25 the APRN documented Resident #1 complained of diarrhea and there was no documentation on the chart about diarrhea. The APRN documented he will order Imodium (antidiarrheal) and probiotics and if patient continues to have diarrhea collect sample for C diff (clostridium difficile, bacteria that causes inflammation of the colon) and put patient in isolation. Monitor for loose, watery stool, bloating, abdominal cramps, and nausea. Monitor for fever, severe pain, vomiting, blood or mucus in stool or weight loss. Monitor for symptoms of dehydration. Medications as ordered: Imodium 2 mg capsules.Review of the Documentation Survey Report for 6/2025 and 7/2025 revealed Resident #1 had large loose stools:On 6/14/25, 6/16/25, 6/18/25, 7/7/25, and 7/8/25 during the day shift (6:00 a.m., to 2:00 p.m.).On 6/28/25 during the evening shift (2:00 p.m., to 10:00 p.m.). On 6/13/25, 6/17/25, and 7/7/25, during the night shift (10:00 p.m., to 6:00 a.m.). There was no documentation in the clinical record the Practitioner was informed Resident #1 had large loose stools.On 8/4/25 at 1:22 p.m., in an interview LPN Staff A said he recalled talking with Resident #1's brother. He said Resident #1 had a lot of fluid in her legs and was on diuretics (medication to help urinate excess fluid). LPN Staff A said, according to the charting, the five days before she was sent to the hospital, Resident #1 had mixed stools, some formed and some loose. He went over the resident's medications with the brother. He said she did not recall anyone telling him they found Resident #1 in diarrhea. The resident's labs indicated she had a urinary tract infection. He talked with the family about getting checked out. Basically, he explained to them what was happening with the resident and what the facility was doing to treat it. He said the scheduled Morphine (pain medication) was causing the slurred speech and they stopped it.On 8/5/25 at 9:23 a.m., in a telephone interview, Resident #1's brother said at the beginning of July 2025 he was on the phone with his sister (Resident #1). She was mumbling, crying, trying to talk, she just couldn't talk. He said he was concerned and flew down to see her. He said several times when he visited, he found her soiled, a mess, diarrhea on the bed. She was having difficulty speaking clearly. He asked his cousin to come to the facility. On Monday 7/7/25, he and his cousin spoke with Licensed Practical Nurse (LPN) Staff A about their concerns related to Resident #1's mentation, medications, finding her in soiled diapers multiple times. They were concerned Resident #1would end up with a urinary tract infection and go septic. They requested to

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record review and interview, the facility staff failed to follow processes to ensure laboratory testing were done as ordered to meet the needs of 3 (Residents #1, #2 and #3) of 3 residents reviewed.The findings included:Review of the facility's policy and procedure titled, Laboratory, Diagnostic and X-Ray with a revision date of 02/02/2024 revealed, Procedure: Obtain a physician's order for laboratory work, diagnostic testing, and x-ray. Complete the required requisition form(s). Schedule laboratory work, diagnostic test and or x-ray as indicated.Review of the clinical record for Resident #1 revealed an admission date of 6/12/25.Review of the progress notes revealed on 7/5/25 the Advanced Practice Registered Nurse (APRN) documented Resident #1 was evaluated for persistent bilateral leg edema (swelling) and shortness of breath. The practitioner documented a CMP (Complete metabolic panel) and Pro-BNP (measures a specific protein) were ordered to monitor electrolytes and volume status. The plan of care was discussed with the nurse. The progress note documented next labs pending were comprehensive panel, CBC (complete blood count) and Pro-BNP.Review of the Treatment Administration Record (TAR) for July 2025 revealed on 7/7/25, the Licensed Nurse placed her initials, indicating Resident #1's blood was drawn for the CMP, CBC and Pro-BNP.On 7/8/25 the APRN documented in a progress note Resident #1 complained of dysuria (painful urination). A urinalysis revealed a urinary tract infection. The APRN documented the laboratory tests were currently pending results to monitor kidney function and electrolytes. On 8/4/25 review of the clinical record for Resident #1 failed to reveal results for the CBC, BMP and Pro-BNP the licensed nurse signed as obtained on 7/7/25.On 8/4/25 at 2:50 p.m., in an interview the Director of Nursing (DON) and Regional Nurse verified the lack of results for the CBC, BMP and Pro-BNP the APRN ordered on 7/5/25. They said they were not aware the resident's blood was never drawn.Review of Resident #2's clinical record on 8/6/25 revealed a practitioner's order for blood work dated 7/24/25 for CBC, Comprehensive Panel and a Hemoglobin A1C. The lab collected blood work on 7/25/25, but not the Hemoglobin A1C. On 8/5/25 a new order was placed for the Hemoglobin A1C. On 8/6/25, review of Resident #3's clinical record revealed a practitioner's order for blood work dated 8/4/25. On 8/5/25, a progress note noted the labs were not drawn. The APRN was notified and the labs were reordered and rescheduled to be drawn on 8/6/25.On 8/6/25 at 10:55 a.m., in an interview the DON said the laboratory is integrated in the facility's electronic clinical record. When a laboratory order is entered in the electronic clinical record, it goes directly to the lab and is automatically transcribed on the TAR. She said the practitioners and licensed nurses who enter lab orders in the electronic clinical records were responsible to print the laboratory requisition and place it in the laboratory binder at the nurse's station. She said the laboratory technician uses the printed laboratory requisition to obtain the residents' specimen. She said the binder also contains a laboratory log where the laboratory technician signs off on the specimen obtained. She said, the licensed nurses or the lab technicians can enter the laboratory testing ordered on the log.Review of the facility provided Lab Monitoring Sheet for July 7, 2025, and July 8, 2025, failed to reveal documentation the CMP, CBC and Pro-BNP were obtained for Resident #1 as ordered.When asked about the process to track lab orders, the DON said the Unit Managers were responsible to ensure the labs were done, the results obtained and reported to the physician. She said the Unit Managers were supposed to pull the 24-hour report for their assigned unit, including the lab orders. In clinical morning meeting, they go over the order listing report.The DON verified the process was not followed for Resident #1, #2, and #3.On 8/6/25 at 11:41 p.m., in an interview the Regional Nurse said on 8/4/25 when they became aware of the missed blood work for Resident #1, they audited the clinical records for missed labs from 7/5/25 through 8/5/25. During the audits, they identified 13 other residents with missing labs, including Residents #2 and #3.