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	11/19/2025

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 - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, resident and staff interviews, the facility failed to ensure staff provided incontinence care in accordance with accepted standards of care to meet the needs of 1 (Resident #800) of 3 residents reviewed.The findings included:On 10/15/25 at 9:24 a.m., Resident #800 was observed in bed in her room. In an interview Resident #800 said staff put two incontinent briefs and a towel on her because she was a heavy wetter. With the resident's permission, the incontinent briefs were observed. Resident #800 was wearing two incontinent briefs. A folded towel was placed inside the briefs. Resident #800 said it took 2 to 3 staff to provide incontinent care and change her briefs. She said the other day Certified Nursing Assistant (CNA) Staff A came in to change her. She tried to explain to the CNA how they did her care and that it took 2 to 3 staff to change her. The resident said that CNA Staff A did not explain what she was going to do and did not listen to her. She reported the incident.Review of the clinical record revealed Resident #800 had an admission date of 9/23/25. Diagnoses included severe morbid obesity, lymphedema (swelling caused by buildup of lymph fluid in body tissues), and chronic pain.Review of the admission Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 9/30/25 documented Resident #800 was dependent on staff for toileting, bathing and dressing. The MDS noted the resident scored 15 on the Brief Interview for Mental Status, indicating the resident's cognitive skills for daily decision making were intact.Review of the care plan for Resident #800 revealed:Resident #800 had non-blanchable redness to the buttocks, actual impairment to skin integrity of the medial thighs and groin secondary to fungus.Resident #800 was incontinent of bladder and bowel (Date initiated: 10/3/25). The goal was for the resident to remain free from skin breakdown due to incontinence and brief use.The interventions included: Clean the peri-area with each incontinence episode. Check for incontinence. Wash and dry perineum. Change clothing as needed after incontinence episode.Resident #800 had Alteration in usual functional performance in self-care related to lymphedema, Diabetes Mellitus, morbid obesity, Congestive Heart Failure, chronic pain and osteoarthritis.The interventions as of 10/3/25 noted:The resident used disposable briefs and was dependent on 3 staff assist for bed mobility (includes rolling from side to side and side to back).Resident #800 was dependent with 3 staff assist for Toilet Hygiene. Staff was to use disposable briefs, and clean peri-area with each incontinence episode. The care plan specified Resident performance: Bed mobility (includes rolling from side to side and side to back) - Dependent with 3 (three) staff assist.On 10/15/25 at 1:30 p.m., in an interview the Director of Nursing (DON) said the practice of putting 2 briefs on incontinent residents was not consistent with the facility's expectations. The DON said the facility's investigation verified that CNAs have been double briefing Resident #800 and other residents who were heavy wetter. She said after the incident, she addressed it in a staff meeting. She provided in-services dated 9/22/25, 9/23/25 and 9/26/25 on abuse, neglect and exploitation. 18 CNAs attended the in-services. The in-services provided did not address the practice of double briefing incontinent residents.Review of the facility provided incident investigation revealed that Resident #800 reported that on 10/5/25 CNA Staff A entered her room between 1:00 a.m. - 3:00 a.m. The resident tried to explain that it usually takes more than one person to help her with care, but the CNA (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	did not listen. The facility's investigation documented Resident #800 was a heavy wetter. CNAs have been putting two disposable incontinent briefs and a wadded towel in front of her personal area.On 10/15/25 at 2:00 p.m., in an interview the Administrator said CNA Staff A did not provide quality of care as expected to Resident #800.