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	01/14/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to prevent verbal abuse from staff for 2 of 3 residents reviewed. (Patient #1 and Patient #2)The findings included: Review of the facility Abuse, Neglect, Exploitation & Misappropriation policy (last revised on 11/16/2022) says that residents should be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. The policy further noted no employee may at any time commit an act of physical, psychological, or emotional abuse. The policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain, or mental anguish. The policy defines mental abuse as the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. The policy defines verbal abuse as the use of oral, written, or gestured communication, or sounds, to residents within hearing distance regardless of age ability to comprehend or disability. The policy noted examples of mental and verbal abuse to include mocking, insulting, ridiculing and yelling or hovering over a resident, with the intent of intimidate. Record review for Resident #1 showed the resident was admitted on [DATE] with a diagnosis of Parkinsons Disease. Resident #1's most recent (10/20/25) Brief Interview for Mental Status (BIMS) was a score of 15 indicating intact cognition.Review of a Patient #1 psychiatric progress note (completed on 12/31/25) stated patient was seen today as staff request for psychiatric evaluation following a reportable incident. Patient reports feeling emotional discomfort following an interaction with a staff member on 12/25/25.During an interview on 1/13/26 at 11:16 a.m., Resident #1 said she was abused by a staff member around Christmas. She said CNA (Certified Nursing Assistant) Staff A came in to change her brief due to an episode of incontinence. She said she has Parkinsons Disease (a neurological disorder that affects movement) causing her to move very slowly and deliberately. Resident #1 said she told CNA Staff A to slow down prior to turning her. Resident #1 said CNA Staff A was yelling at me the whole time and not listening. Resident #1 said CNA Staff A was yelling at me with a tone and attitude of I have to get this done as fast as possible. Resident #1 said CNA Staff A grabbed the sheet and whipped me to the side. Resident #1 said she caught the windowsill which prevented her from hitting the floor. Resident #1 said CNA Staff A not listening to me and moving me rough like that made me feel inconsequential, like I don't matter to her.Review of the facility complaint/grievance reported on 12/25/25 from Resident #1 stated, CNA Staff A was verbally abusive by calling her ‘heavy' and stating ‘I don't get paid enough to do this. My back hurts'. Resident stated CNA ‘bitched at me for not being able to get into my wheelchair'. Resident stated CNA rolled her over onto her right side ‘so rough using the pad, I thought I was going to fall onto the floor'. Resident stated she overheard CNA yelling to night nurse about her.Review of a statement on 12/25/25 by LPN (Licensed Practical Nurse) Staff B said Resident #1 had turned on her call (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	light, the CNA (Staff A) had just been in there and said out loud like what she wants now or something to that effect. LPN Staff B said CNA Staff A likes to talk loudly, so even though she was having a conversation with me and venting about the job, she was loud enough that Resident #1 could hear her through a shut door. In fact, Resident #1 actually called the nurses station and told me that if she has got time to talk, then she has time to change her.Review of a witness statement on 12/25/25 by Resident #2 (Resident #1's roommate) said the CNA was very loud and mean talking to Resident #1. She told Resident #1 she could break her back changing her.Record review for Resident #2 showed a most recent BIMS score of 13, dated 7/25/25, indicating intact cognition.During an interview on 1/13/26 at 12:01 p.m., Resident #2 said CNA Staff A treated Resident #1 very badly that night around Christmas. Resident #2 said, I have never seen anyone treat anybody the way she did. Resident #2 said CNA Staff A was yelling at Resident #1 while changing her brief. Resident #2 said, I was so nervous because of what was going on. Resident #2 said, it made me scared and I covered my face and hid under my blanket. Resident #2 said, I was scared of the woman and was scared of what she would do to me if I spoke up. I did not get involved due to this. I just hid.During an interview on 1/13/26 at 12:36 p.m., Resident #3 said CNA Staff A would come into my room in the middle of the night, slam on the lights and not explain anything. Resident #3 said you had to do it her way. Resident #3 said CNA Staff A used to yell at me all of the time. She would be nasty to my roommate as well. I feel bad for my roommate because he is very old and not with it sometimes. She would come in and yell at him. I always felt bad for him. She would always talk down to both of us as though she was entitled. Resident #3 said CNA Staff A was eventually not allowed in his room anymore. During an interview on 1/13/26 at 2:12 p.m., the Administrator said she came into the facility on Christmas due to an allegation of abuse. The Administrator said she collected statements, including statements from Resident #1 and Resident #2. The Administrator said both residents have a BIMS of 15 (indicating intact cognition). The Administrator said they did substantiate the allegation of abuse when the investigation was complete.