STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105588	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility's policies and procedures, resident representative and staff interviews, the facility failed to allow the return to the facility post hospitalization for 1 (Resident #2) of 7 residents reviewed for discharge planning process.Resident #2 was discharged to a different nursing home approximately 73 miles from his family.The findings included:Review of the facility's policy and procedure titled, Transfer/Discharge Notification & Right to Appeal with a revision date of 04/28/25 revealed, Transfer and discharges of residents, initiated by the center (facility initiated) will be conducted according to Federal and/or State regulatory requirements. The center must permit each resident to remain in the center, and not transfer or discharge the resident unless:The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the center;The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the center;The safety of individuals in the center is endangered due to clinical or behavioral status of the resident;The health of individuals in the center would otherwise be endangered. Emergency transfers to Acute Care: Residents who are sent emergently to an acute care setting, must be permitted to return to the center. If the Center initiates a discharge while the resident is in the hospital, the center must show evidence that the resident's status at the time of the return to the center meets the criteria listed above (A-D) .Review of the clinical record for Resident #2 revealed an admission date of 8/26/25. Diagnoses included Chronic viral Hepatitis C, Problem with Social Environment, Unspecified Anxiety Disorder, History of Traumatic Brain Injury, Mild cognitive Impairment of unknown origin, Mood Disorder due to known Psychological Condition with Mixed Features, and Adjustment Disorder with Mixed Anxiety and Depressed Mood.Review of the Minimum Data Set (MDS) Assessments revealed:The Quarterly MDS with an assessment reference date of 3/4/26 revealed Resident #2 scored 15 of 15 on the Brief Interview for Mental Status (screening to assess cognition, specifically memory and orientation), indicating intact cognition. The MDS noted that Resident #2 did not exhibit physical or verbal behavioral symptoms directed toward others.The Discharge MDS assessment with an observation end date of 3/20/26 revealed that on 3/20/26 Resident #2 had an unplanned discharge-return anticipated. The MDS noted that Resident #2 did not exhibit physical behavioral symptoms directed toward others or verbal behavioral symptoms directed toward others. Review of Resident #2's care plan revealed:The resident wished to stay Long Term Care (LTC) at the facility (Date initiated 9/1/25).Resident #2 was verbally aggressive towards staff (Date initiated 10/30/25). The goal was for the resident to demonstrate effective coping skills.Resident #2 had behaviors of yelling at other residents and telling them to Shut your mouth (Date initiated 2/24/26). The goal was for the resident to have fewer episodes of the behavior. Review of the progress notes revealed:On 3/20/26 the Psychiatric Provider documented that Resident #2 has been manic, psychotic, delusional and responding to internal stimuli. He has a history of psychosis, and he has been presenting with bizarre and tangential behavior. He has refused all medications or staff care and assistance that could help redirect him. He is being aggressive, impulsive refusing medications and is a danger to self. (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: 105588	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2026
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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 has failed all interventions by staff to keep him safe. He requires a higher level of care to ensure his safety and the safety of others. The Psychiatric Provider documented that Resident #2 required to be baker acted (involuntary, emergency examination). On 3/20/26 at 5:29 p.m., the Director of Nursing (DON) documented in a late entry, Resident had a burst of anger with uncontrolled behavior screaming, kicked the entrance door of his room and created a hole on the wall. He messed up his bed sheets as well, kicked the wall by his TV across from his bed TV, creating big hole, carrying on for approximately 1/2 hour, notified law enforcement . Psych Provider ordered to [NAME] Act. Law enforcement arrived followed by EMS (Emergency Medical Services). [NAME] Act order from (Psychiatric Provider) was presented to the law enforcement and EMS. When law enforcement arrived, resident had calm [sic] down but from clinical standpoint, the inappropriate behavior presented by the resident and witnessed by me and several staff and other alert residents was frightening and resident needs to be out of the facility for staff and other residents' safety. Resident's mother arrived and was fully aware of his inappropriate behavior. Resident left the facility via stretcher w/EMS (with) and law enforcement approximately 6 PM.On 3/22/26 at 3:52 p.m., the DON documented that Resident #2 was being admitted . She spoke with the case manager who will be available the next day to discuss discharge plan for the resident.The clinical record lacked documentation that a bed hold policy was offered to the resident or representative at the time of transfer to the hospital.Review of the hospital record revealed that Resident #2 was admitted on [DATE] and discharged on 3/23/26. The hospital course synopsis documented that Resident #2 was admitted under involuntary commitment for evaluation of mental health concerns following reported aggression at his memory care facility. On admission, Resident #2 was calm, cooperative, and oriented, with no evidence of acute distress or psychiatric complaint. He denied suicidal or homicidal ideation and was medically cleared in the Emergency Department. He was not accepted for psychiatric facility placement due to wheelchair dependence and chronic immobility.The psychiatric evaluation, including a telemedicine consult determined that Resident #2 did not meet criteria for involuntary inpatient or outpatient psychiatric placement. The [NAME] Act orders and associated safety protocols were discontinued. He was cleared for discharge from a psychiatric perspective with recommendations for intensive outpatient neurocognitive rehabilitation and provision of outpatient mental health resource information. Case management and social work were involved in discharge planning, as his prior skilled nursing facility refused to accept him back, and alternative placement options specializing in Traumatic Brain Injury were discussed with his emergency contact.On 4/14/26 at 11:00 a.m., in an interview, the DON verified that there was no documentation Resident #2 was offered a bed hold at the time of the transfer to the hospital. She said that Resident #2's emergency contact declined the bed hold. The DON said that when Resident #2 was ready to be discharged from the hospital, the facility refused to take him back. She thought that Resident #2 would be better off in a group home due to his age and volatile behavior.On 4/14/26 at 12:01 p.m., in a telephone interview, the emergency contact said since the facility refused to allow Resident #2 to come back, he was placed in a nursing home located approximately 73 miles and 2-hour drive from her house. She said that Resident #2 fell at the new facility once in the middle of the night and called her screaming for help. It caused her much distress since she could not get to him. The emergency contact said that Resident #2 was not available for an interview, but she would like for him to return to the facility. On 4/14/26 at 12:54 p.m., in an interview, the Admissions Director said that approximately 4 to 5 days after Resident #2 was transferred to the hospital under a [NAME] Act, the hospital notified them that he was ready to return to the facility. She said that her regional leader told her not to accept the resident and that he was not to be accepted to any of their sister facilities.On 4/14/26 at 12:57 p.m., in an interview, the Administrator said that a bed hold was not offered to Resident #2 and there was no documentation of the basis for discharge of the resident. She said the regional team decided to not allow Resident #2 to return to the facility, based on the information provided by facility staff.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility's policy and procedure and staff interviews, the facility failed to provide immediate and appropriate basic life support to 1 (Resident #1) of 3 residents reviewed with full code status (Administer cardiopulmonary resuscitation in the event of cardiac or respiratory arrest).On [DATE] at approximately 2:07 a.m., the clinical staff consisting of one Registered Nurse (RN) and one Licensed Practical Nurse (LPN) administered Cardiopulmonary resuscitation (CPR) to Resident #1 when he was found without a pulse or respirations. The Licensed Nurses did not activate Emergency Medical Services (EMS) and discontinued CPR after approximately 20 minutes. The RN pronounced the resident's death without the required credentials. Clinical staff re-started CPR 4 hours later at the direction of the Director of Nursing and called EMS. Resident #1 was pronounced deceased by EMS.The facility failure to immediately activate EMS and administer CPR to Resident #1 until the arrival of EMS placed other residents with full code status at a likelihood of serious injury or death from not receiving appropriate lifesaving interventions in the event of cardiac and/or respiratory arrest. This failure resulted in the determination of Immediate Jeopardy (IJ).On [DATE], after verification of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed, effective [DATE]. The scope and severity were reduced to D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.The findings included:Cross Reference F726Review of the facility's policy and procedure titled, Florida Cardiopulmonary Resuscitation (CPR) with a revision date of [DATE] revealed, Cardiopulmonary Resuscitation (CPR) will be provided to all residents who are identified to be in cardiac arrest unless such resident has a fully executed Florida Do Not Resuscitate (DNR) order. In the event of cardiac arrest, immediately call for assistance . Use the page system and call Code Blue to Room Number or location of the event three times. In the absence of a fully executed Florida Do Not Resuscitate order . the facility will immediately begin CPR. Center staff will continue performing CPR until Emergency Medical Technicians assume responsibility for CPR, or it may be discontinued if the resident responds .Review of the clinical record for Resident #1 revealed an admission date of [DATE]. Diagnoses included Peripheral Vascular Disease (a slow-progressing circulation disorder involving the narrowing, blockage, or spasms of blood vessels), Chronic Obstructive Pulmonary Disorder (a condition that restricts airflow and makes breathing difficult), Vascular Dementia and Alzheimer's Disease.The physician's order dated [DATE] specified Full Code status.The care plan initiated on [DATE] noted that Resident #1had, Incapacity and Guardianship by Court Order honoring his wishes Full Code.On [DATE] at 2:07 a.m., RN Staff A wrote in a nursing progress note, CNA (Certified Nursing Assistant) called me. She found the resident unresponsive in his bed at 2:07 am. Assessment: Absence of pulse/Respiration. Pupils do not respond. DON (Director of Nursing), Guardian and Provider was [sic] notified.On [DATE] at 6:00 a.m., the DON wrote in a progress note, Received a message from assigned Nurse that resident has no pulse, no respiration, no blood pressure. It was reported that a CNA found the resident, assigned nurse-initiated CPR, EMS was notified, arrived at facility, continue CPR, unable to revive resident. EMS pronounced resident expired at 6:31 AM with Diagnosis: Sudden Cardiac arrest.Review of the EMS Patient Care Record dated [DATE] revealed EMS was activated on [DATE] at 6:18 a.m., arrived at the facility at 6:27 a.m., and pronounced Resident #1's death at 6:31 a.m. The EMS report noted that the patient's jaw was locked and non-moveable. The patient's extremities were stiff and unmovable. The narrative noted that on arrival, facility staff was doing active CPR. Resuscitation was not attempted-Considered Futile. The first impression was Rigor Mortis (postmortem stiffening of the muscles), Algor Mortis (postmortem cooling of the body), Apneic (cessation of breathing), Pulseless and Unresponsiveness. EMS documentation noted facility staff on scene stated the last time they saw the pt (patient) was 11pm last night. On [DATE] at 9:44 a.m., in an interview, the Administrator (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	said that they investigated the incident and concluded that on [DATE] at 2:00 a.m., 911 was not called when Resident #1 was found unresponsive.Review of the facility provided investigation revealed:On [DATE], Certified Nursing Assistant (CNA) Staff C wrote in a witness statement that on [DATE] at 2:00 a.m., she found Resident #1 unresponsive and immediately notified RN Staff A. RN Staff A said that she already knew that the resident was going to die and instructed her to clean the resident. Another CNA helped her clean and cover Resident #1.On [DATE] RN Staff A documented in a witness statement that on [DATE] around 2:00 a.m., one of the caregivers told her that she thought Resident #1 was dead. She ran to the door, called LPN Staff B and said, Hey Code Blue. LPN Staff B brought the crash cart and they started CPR. RN Staff A said they administered CPR to Resident #1 for approximately 20 minutes. She told LPN Staff B that the resident had no vital signs (pulse, respiration, blood pressure) but he was warm and not responding at all. She thought Resident #1 was in hospice and that was the reason why she did not call 911. On [DATE] at approximately 5:50 a.m., the DON called and asked her if she had called 911. She then immediately called 911. They arrived at 6:00 a.m. and took control of the situation.On [DATE], LPN Staff B wrote in a witness statement that a Certified Nursing Assistant (CNA) notified RN Staff A that Resident #1 was unresponsive. RN Staff A checked her report sheet and called a code blue. He took the crash cart to the room, and they administered CPR to the resident. After about 20 minutes, RN Staff A called it off and said something about, He was gone or words to that effect. RN Staff A then started calling people.On [DATE], CNA Staff D wrote in a witness statement that she came in to work early on [DATE]. RN Staff A asked her to put the board under Resident #1 (Firm board to ensure effective chest compressions during CPR) and do compressions. She was doing compressions when EMS arrived. One minute later, EMS told her to stop the compressions. She left the room.On [DATE] at 10:39 a.m., in a telephone interview, CNA Staff D said that on [DATE] at around 6:00 a.m., RN Staff A asked her to place the board under Resident #1 and do chest compressions until EMS arrives. She had done 5 or 6 compressions when EMS arrived. She continued the chest compressions until EMS told her to stop.On [DATE] at 11:20 a.m., in a telephone interview, RN Staff A said that on [DATE] she was the nurse in charge for the night shift. At approximately 2:00 a.m., CNA Staff C told her that she thought Resident #1 had died. She yelled Code Blue and yelled for help. LPN Staff B brought the crash cart, and they administered CPR to the resident. After 3 to 5 rounds of CPR, she told LPN Staff B that Resident #1 was not there anymore. She said, I don't pronounce anyone dead, but he was without vital signs. She called the CNAs and they cleaned him up. RN Staff A verified she did not call 911 and discontinued CPR. RN Staff A said, This is not my normal resident. I thought he was hospice, so I did not call 911. She notified the DON, the Provider and Resident #1's family members. She said at approximately 5:50 a.m., the DON called the facility and asked if she had called 911. She told the DON that she had not called 911 since she was by herself with the CNA and LPN Staff B. RN Staff A said she told the DON that she was confused about who was on hospice and who was a full code. RN Staff A said, I don't pronounce them dead, but I knew he was dead, no vitals, no respirations. Nurses don't pronounce residents dead. We found him dead, we know he is dead because it is clinical. RN Staff A said the DON instructed her to call 911. She said she reinitiated CPR at 6:00 a.m. after calling 911. RN Staff A said, We tried to do something until EMS came because they have to see us doing CPR. They repronounced him dead after that. RN Staff A verified that she reinitiated CPR approximately 4 hours after Resident #1 had no pulse or respirations and CPR was stopped.On [DATE] at 1:22 p.m., in an interview, the DON said that on [DATE] at 2:42 a.m., RN Staff A sent her a text message letting her know that Resident #1 had expired. She called the facility at approximately 6:00 a.m., and instructed RN Staff A to call 911. She did not know why RN Staff A reinitiated CPR. She verified that the facility's investigation determined that RN Staff A and LPN Staff B did not follow the facility's established policy and procedure to call 911 and administer CPR to Resident #1 until the arrival of EMS.On [DATE] at 8:48 a.m., in a telephone interview, CNA Staff C said that on [DATE] at around 2:00 a.m., she found Resident #1 unresponsive and immediately notified RN Staff A. CNA Staff C said (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	that RN Staff A came to the resident's room, took vital signs then instructed her to clean the resident.On [DATE] at 3:11 p.m., in a telephone interview, the Medical Director said that Resident #1 was a full code. They should have started CPR and called 911. He said that CPR should not be done 4 hours after a resident is pronounced On [DATE], the survey team verified through review of the CPR certification for all licensed nurses currently employed at the facility.Starting on [DATE], the Director of Nursing and/or nursing management educated licensed nurses on CPR policy and procedure and Florida DNRO (Do Not Resuscitate Order) policy. This included where to find the code status. Education also addressed what to do for scenario with full code hospice residents. Education was completed on initiating EMS services immediately when a resident is full code. Education included that CPR is to continue on a full code resident until EMS arrives and that the nurse cannot pronounce death on the full code resident and/or stop CPR until instructed by EMS. 32/32 licensed nurses have been educated.On [DATE], the survey team verified through review of the education provided and interview with 3 licensed nurses and 2 CNAs. On [DATE], 3 additional licensed nurses interviewed verified receipt and content of the education.Starting immediately on [DATE], Nursing Management conducted Emergency response code blue drills were conducted daily on all three shifts. Drills are ongoing daily on all three shifts with compliance noted. Drills included full code, DNR, and Full code hospice scenarios. Full code drills included emphasis on calling EMS immediately. 30/32 licensed nurses have participated. The remaining 2 licensed nurses are PRN (as needed) and have not worked since [DATE]. They will participate prior to their next working shift. 46/46 CNA's have participated.On [DATE], the survey team verified through review of the content of the daily emergency response code blue drills on all 3 shifts. On [DATE], 3 licensed nurses and 2 CNAs were interviewed and verified participation in code blue drills and verified content of the emergency response for full code residents. On [DATE], interview with 3 additional licensed nurses verified participation in code blue drills and emergency response when a resident is found in cardiac and/or respiratory arrest. Starting on [DATE], the Administrator and/or Nursing Management educated the licensed nurses and CNAs regarding the facility abuse and neglect policy, including resident rights. 32/32 licensed nurses have been educated. 46/46 CNAs have been educated.On [DATE], the survey team verified through review of the documentation of the education provided and interview with 3 licensed nurses and 2 CNAs.Starting on [DATE] licensed nurses received and completed a DNRO post-test. 30/32 licensed nurses have completed a DNRO post-test with 100% accuracy. The remaining 2 licensed nurses are prn and will complete the test prior to their next working shift.On [DATE], the survey team verified through record review that 30 licensed nurses completed the DNRO post-tests. On [DATE], interview with 3 licensed nurses verified that they received the training and completed the DNRO post-test. On [DATE] at 2:52 p.m., in an interview, the Administrator said that the 2 employees who have not completed their training will not be allowed to work until they complete the education.Starting on [DATE], the Director of Nursing and/or nursing management educated licensed nurses regarding change in condition. 30/32 licensed nurses have received the education. The remaining 2 licensed nurses are PRN will complete the test prior to their next working shift.On [DATE], the survey team verified through review of the education provided regarding change in condition and interview with 3 licensed nurses.Starting on [DATE] the Administrator placed laminated instructions on how to overhead page during a code for all four nursing station phones, the activity office phone, and the therapy gym phones.On [DATE] at 2:29 p.m., the survey team verified through observation that all 4 nurse's stations, the activity's office and the therapy gym's phone had laminated instructions on how to overhead page during a code.On [DATE] an ADHOC (unplanned) Quality Improvement Performance Committee meeting was held to review the recommendations made from the root cause analysis. The root cause analysis showed that the nurse believed the resident was hospice and did not start CPR or call EMS when the resident was found without respirations and pulse. The root cause of this was that she did not check the code status as outlined in the facility policy. All recommendations were approved by the committee. The following team members were in (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	attendance: Medical Director (via telephone), Executive Director, Regional Director of Clinical Services (via telephone), Director of Nursing, Assistant Director of Nursing, Social Services, MDS (Minimum Data Set), Unit Manager, Business development Coordinator, Director of Patient Experience, Business Office Manager, Maintenance Director, Nutrition Director, Housekeeping Director, and Activities Director.On [DATE], the survey team verified through record review and interview with the Administrator that a Quality Improvement Performance Committee meeting was held on [DATE] and discussed the root cause of the incident and the recommendations were approved by the committee. The root cause documented was, staff knowledge on when CPR can be discontinued and when 911 is called. Nurse did not check code status. Policy not followed. The survey team verified participation of team members listed on the facility's removal plan.On [DATE], a follow-up Ad HOC Quality Improvement Performance Committee meeting was held to review plan progress. All recommendations were approved by the committee. The following team members were in attendance: Medical Director, Executive Director, Regional Director of Clinical Services (via telephone), Director of Nursing, Assistant Director of Nursing, Social Services, MDS (2), DON traveler, Unit Managers (2), Business development Coordinator, Director of Patient Experience, Business Office Manager, Maintenance Director, Nutrition Director, Housekeeping Director, and Activities Director.On [DATE], the survey team verified that on [DATE] the facility held a Quality Improvement Performance Committee meeting and reviewed the plan's progress. The survey team verified participation of team members listed on the facility's removal plan.On [DATE], the Regional Nurse Consultant completed a like resident audit. All expired residents and re-hospitalizations from [DATE] through [DATE] were reviewed to see if involved staff were the same as code event and if proper procedure was followed. Staff identified in incident were not involved in previous codes or re-hospitalizations. All codes were handled per policy.On [DATE], the survey team verified through record review and interview with the Administrator and DON that, on [DATE] the Regional Nurse Consultant completed an audit of all expired and re-hospitalized residents from [DATE] through [DATE] to ensure proper procedure was followed and all codes were handled per facility's policy. Staff identified in the incident involving Resident #1 were not involved in previous codes or re-hospitalization. Review of the clinical records for 2 residents listed on the audit revealed no concern. One resident coded at the facility and staff acted appropriately. One resident was appropriately transferred to the hospital and coded at the hospital.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policies and procedures, and staff interviews, the facility failed to ensure clinical staff had the competencies to respond appropriately to emergencies and ensure 1 (Resident #1) of 3 residents reviewed with full code status (Administer cardiopulmonary resuscitation in the event of cardiac or respiratory arrest) received timely life saving measures when found without pulse or respirations.Resident #1 had a full code status. On [DATE], Resident #1 was found in cardiac and respiratory arrest. Clinical staff administered cardiopulmonary resuscitation (CPR) for 20 minutes then pronounced the resident's death without authority to do so and without activating Emergency Medical Services (EMS). Clinical Staff re-started CPR and activated EMS 4 hours after CPR was stopped and the resident had no pulse and respirations.The facility failure to ensure nursing staff were trained and competent to respond appropriately to cardiac and respiratory arrests placed other residents with full code status at risk of significant delay in receiving lifesaving emergency treatment when found without pulse or respirations and resulted in the determination of Immediate Jeopardy.On [DATE], after verification of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed, effective [DATE]. The scope and severity were reduced to D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.The findings included:Cross reference F678.Review of the Facility Assessment Tool updated [DATE] revealed, List all staff training and competencies needed by type of staff. Consider if it would be helpful to indicate which competencies are reviewed at the time the staff member is hired, and how often they are reviewed after that. Consider the following training topics . Identification of resident changes in condition, including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention . Consider the following competencies . Person-centered care .person-centered care planning . end-of-life care, and advance care planning . Review of the facility's policy and procedure titled, Florida Cardiopulmonary Resuscitation (CPR) with a revision date of [DATE] revealed, Cardiopulmonary resuscitation (CPR) will be provided to all residents who are identified to be in cardiac arrest unless such resident has a fully executed Florida Do Not Resuscitate (DNR) order. Procedure. In the event of cardiac arrest, immediately call for assistance . In the absence of a fully executed Florida Do Not Resuscitate order . the facility will immediately begin CPR. Center staff will continue performing CPR until Emergency Medical Technicians assume responsibility for CPR, or it may be discontinued if: The resident responds.Review of the facility provided incident investigations revealed that on [DATE] at approximately 2:07 a.m., clinical staff consisting of Registered Nurse (RN) Staff A and Licensed Practical Nurse (LPN) Staff B failed to respond appropriately when Resident #1 with a full code status was found without a pulse or respirations. The nurses did not activate EMS and discontinued CPR after 20 minutes. RN Staff A pronounced the resident's death without authority to do so. RN Staff A restarted CPR, four hours after she pronounced the resident's death, and activated Emergency Medical Services (EMS) per the Director of Nursing's instruction. EMS pronounced the resident's death on [DATE] at 6:31 a.m.Review of the Facility provided meeting minutes dated [DATE] revealed that the root cause of the incident was, Staff knowledge on when CPR can be discontinued and when 911 is called. Nurse did not check code status. On [DATE] at 10:39 a.m., in an interview, CNA Staff D said that on [DATE] at approximately 6:00 a.m., RN Staff A instructed her to put the board (Stiff board to ensure effective chest compressions) under Resident #1 and asked her to administer chest compressions to the resident. She did roughly 5 or 6 compressions before EMS arrived. She continued the chest compressions until EMS told her to stop.On [DATE] at 11:20 a.m., in a telephone interview, RN Staff A said that on [DATE] at 2:07 a.m., she did not activate EMS when Resident #1 with a full code status was found without a pulse or respirations. She asked LPN Staff B for help. They administered CPR for 20 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105588	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2026

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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	minutes then stopped. RN Staff A said that nurses do not pronounce residents death and said, I knew he was dead, no vitals, no respirations. We found him dead, we know he is dead because it is clinical. She said that she was confused on who was hospice and who was a full code. She said, I thought he was hospice, so I did not call 911. RN Staff A said that on [DATE] at approximately 6:00 a.m., 4 hours after CPR was stopped, the Director of Nursing (DON) called the facility and instructed her to call EMS. RN Staff A said, We tried to do something until EMS came because they have to see us doing CPR. They [EMS] repronounced him [Resident #1] dead after that.On [DATE] at 11:38 a.m., in a telephone interview, LPN Staff B verified that on [DATE] at approximately 2:07 a.m., RN Staff A asked for his help when Resident #1 was found unresponsive. He said, I thought she had called 911. We did CPR for about 20 minutes, and she [RN Staff A] called the code. I did not call 911 because I was doing compressions. He said that RN Staff A told him, Oh, we are not going to bring him back, so she called the code (stopped CPR) and left. He said that RN Staff A was the charge nurse but he should have spoken up since he knew to continue CPR until the arrival of EMS. The Director of Nursing called the facility at approximately 6:00 a.m. and instructed RN Staff A to activate EMS. They called 911 and restarted CPR at that time. He said that RN Staff A did not say why they restarted CPR, no one said anything. It was strange.Review of RN Staff A's employee file revealed a date of hire of [DATE].RN Staff A's job description titled, Clinical Nurse I (RN), dated [DATE] revealed the job function included, Responsible for providing direct resident care in accordance with established plans . Duties and Responsibilities . Assist nursing personnel to act in compliance with corporate policies, procedures and regulatory requirements.Provide routine nursing services for residents as directed . Education & Certification . Must have CPR Certifications . Specific Requirements . Must possess the ability to make independent decisions when circumstances warrant such action . RN Staff A did not sign the job description to acknowledge that she had read the job description and agreed to perform the tasks outlined in the job description in a safe manner and in accordance with the facility's established policies and procedures.Review of RN Staff A's BLS (Basic Life Support)/CPR Certification revealed a completion date of [DATE]. The certification did not document a hands-on session either in a physical or virtual instructor-led setting in accordance with accepted national standards.On [DATE] at 12:33 p.m., in a telephone interview, a representative of the BLS/CPR provider company where RN Staff A completed her BLS/CPR certification said that the BLS/CPR certification was fully online, was not led by an instructor and had no live feedback.Review of the facility's Skills Competency Assessments for New Hires revealed, Evaluating and documenting competency of staff is required upon hire, annually and as otherwise indicated. Completed Skills Competency Assessment should be retained in employee personnel file .RN Staff A's personnel file did not include a Skills Competency Assessment.Review of LPN Staff B's Clinical Nurse I (LPN) job description signed and dated [DATE] with a date of hire of [DATE] revealed, Duties and Responsibilities . Act in compliance with the company, regulatory and professional standards and guidelines . Education & Certifications . Must have CPR Certifications . Specific Requirements . Must demonstrate knowledge and skills necessary to provide care appropriate to the age-related needs of the residents served . Must possess the ability to make independent decisions when circumstances warrant such action . Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to nursing care facilities.Review of LPN Staff B's BLS/CPR certification dated [DATE] revealed that it was valid for 2 years. Review of CNA Staff D's personnel file revealed a Certified Nursing Assistant /State Tested Nursing Assistant job description signed and dated [DATE] with a date of hire of [DATE]. The job description did not include BLS/CPR certification as an education requirement.CNA Staff D's personnel file included a BLS/CPR certification with an issue date of [DATE] and specified to renew by 09/2025.On [DATE] at 1:22 p.m., in an interview, the Assistant Director of Nursing (ADON) verified that LPN Staff B's BLS/CPR certification dated [DATE] was valid for 2 years, therefore was expired. The ADON also verified that CNA Staff D's BLS/CPR certification specified a renew date of 09/2025 and was (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	expired. He said that per facility policy, CNAs were not allowed to do CPR, including chest compressions and that nurses were expected to renew their CPR certifications. The Human Resources department was responsible to review the nurses CPR certifications upon hire and annually and notify the nurses 90 days before their CPR certification expired.On [DATE] at 12:04 p.m., in an interview, the Assistant Director of Nursing (ADON) said since he started employment at the facility in [DATE], they have been conducting monthly Code Blue (cardiac/respiratory arrest) Drills. He said that RN Staff A went from working the night shift to working the day shift and went back to the night shift. RN Staff A then became the facility's weekend supervisor but had not participated in any Code Blue drill. Review of the facility provided monthly code blue drills for 11/2025, [DATE], [DATE], February 2026 and [DATE], failed to reveal documentation of RN Staff A's participation.On [DATE] at 10:28 a.m., in an interview, the Nursing Home Administrator said that RN Staff A received no orientation or skills competency evaluation since her hire date of [DATE] and was promoted to the weekend supervisor's position on [DATE].On [DATE] at 10:30 a.m., in an interview, the Human Resources Director, and the Director of Training verified that RN Staff A had no onboarding education, no orientation and no nursing competency evaluations on file.On [DATE] at 10:38 a.m., an interview was held with the DON and the ADON. The DON said that newly employed licensed nurses are expected to have 3 days of clinical orientation and complete skills competency evaluations. The licensed nurses must meet expectations. She said, No one should be working on the floor without completing orientation and skills competencies.The ADON said that the Administrator, DON and Human Resources were responsible to ensure staff completed orientation and skills competencies. He said that RN Staff A failed all the tests for the Clinical Manager's position and should not have been a Unit Manager. He said that RN Staff A, cut corners and got away with it. On [DATE] at 11:31 a.m., in an interview, the Administrator said that each department had a part in the onboarding process of new employees. She said that there was also a clinical orientation. She confirmed that there were no records that RN Staff A completed orientation or skills competencies before being promoted to the weekend supervisor's position.On [DATE], the immediate actions implemented by the facility and verified by the survey team included:On [DATE], the Regional Director of Clinical Services verbally educated the Administrator and Director of Nursing regarding the CPR policy and need to immediately contact EMS services in the event of a full code. The administrator and DON signed the education on [DATE]. On [DATE], the survey team verified documentation dated [DATE], that the Regional Director of Clinical Services educated the Administrator and Director of Nursing regarding the CPR policy and need to immediately contact EMS services in the event of a full code.Starting on [DATE], the Director of Nursing and/or nursing management educated licensed nurses on CPR policy and procedure. This included where to find the code status. Education also addressed what to do for scenario with full code hospice residents. Education was completed on initiating EMS services immediately when a resident is full code. Education included that CPR is to continue on a full code resident until EMS arrives and that the nurse cannot pronounce death on the full code resident and/or stop CPR until instructed by EMS. 32/32 licensed nurses have been educated.On [DATE], the survey team reviewed the content of the education and verified that 32 of 32 licensed nurses were educated. On [DATE], 3 licensed nurses and 2 CNAs verified receipt and content of the education related to CPR policy and procedure. On [DATE], 3 additional licensed nurses were interviewed. Each licensed nurse verified receipt of the education and verbalized content of the education related to the facility's CPR policy and procedure.On [DATE], an Ad HOC (unplanned) Quality Improvement Performance Committee meeting was held to review the recommendations made from the root cause analysis. The root cause analysis showed that the nurse believed the resident was hospice and did not start CPR or call EMS when the resident was found without respirations and pulse. The root cause of this was that she did not check the code status as outlined in the facility policy. All recommendations were approved by the committee. The following team members were in attendance: Medical Director (via telephone), (continued on next page)

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