STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105257	A. BUILDING B. WING	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIATA AT SAINT LUCIE	611 S 13TH ST , FORT PIERCE, Florida, 34950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An unannounced complaint survey for complaint number 2026003505, 2026003651, and 2026004646 was conducted on and at Aviata at St. Lucie. The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: 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 with pertinent diagnosis of , valve. Further review of the physician orders revealed that the physician prescribed on ( ) 5 mg by every other day for valve replacement to begin on and she prescribed for labs for (/INR), with diff and comprehensive panel (CMP). However, the labs drawn for /INR are noted as invalid. Then on	F0684	F0684 Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. this plan of correction is prepared and/or executed solely because it is required (1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A. On resident #1 was discharged from facility to Lawnwood Regional Medical Center. B. On Physician was notified of prior events and current conditions for resident discharged to Lawnwood Regional Medical Center on . No additional residents were affected at this time. C. On , comprehensive medication and lab review for resident #1 was completed to ensure all physician orders are current and being followed; resident transferred to hospital prior to additional interventions being implemented. D. As of , the licensed nursing staff identified in the deficient practice are no longer employed by the facility. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;	

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIATA AT SAINT LUCIE	**611 S 13TH ST , FORT PIERCE, Florida, 34950**

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F0684 SS = D	Continued from page 1 at 5:23 PM, the physician prescribed to hold pending /INR results. On , the nurse noted that the results of the /INR were received and the physician was contacted. The physician prescribed for the resident to receive 2.5 mg on and to resume 5.0 mg daily on . Review of the Medication Administration record for Resident # 1 revealed that the nurses placed their initials in the appropriate boxes to indicate that the 2.5 mg was administered on and 5.0 mg was administered on , and . Further review of the physician orders revealed that the 5 mg was placed on hold to and to . However, the nurse documented that the resident's INR was 3.38 on and . Additionally, the 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 . On when the INR was noted as critically elevated at 17.63, the physician prescribed for the resident to received K 10 mg injection and to have the /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 . 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 . Review of the Medication Administration Record (MAR) revealed multiple entries for Oral Tablet 5 MG on , , and : 2.5 mg on . An interview was conducted on at 2:30 PM with the Director of Nursing, who confirmed the labs were not drawn on and . The labs were not drawn until . She further confirmed there is no evidence that the nurses contacted the physician before noting they administered the 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 on when the INR was 9.12. That nurse no longer works for the	F0684	Continued from page 1 A. On , the Director of Nursing/Designee identified and reviewed current residents receiving , , . The review included verification of current physician orders, review of /INR results and therapeutic ranges, confirmation of timely laboratory draws, and verification of appropriate medication and documentation. At the time of the review, there were no residents in the facility receiving / , , ; however, all other therapies were reviewed. Any discrepancies identified during the review were immediately corrected, including physician notification and clarification orders. (3) What measures will be put into place or what systematic changes you will make to ensure A. By , the facility implemented system changes, including the establishment of an Management Protocol outlining INR critical value parameters, required interventions for elevated INR levels, and mandatory physician notification guidelines. A Lab Tracking Log was also implemented to ensure all ordered laboratory tests are completed as scheduled, reviewed in a timely manner, and escalated appropriately when not obtained. In addition, High-Risk Medication Audits Tool for was put into place to monitor compliance and medication safety practices. Education was completed with licensed nursing staff regarding the administration, monitoring, management of / , , , including therapeutic INR ranges, timely physician notification, documentation requirements, and appropriate interventions for abnormal lab values. B. By , Licensed Nursing Staff will have been educated by Director of Nursing/designee on the components of F684 with an emphasis on medication administration safety, documentation accuracy, and appropriate clinical decision-making and escalation protocols. C. Newly hired licensed nursing staff will receive education by the Director of Clinical/Designed on the components of F684 with an emphasis on medication administration safety, documentation accuracy, and appropriate clinical decision-making and escalation protocols. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place:	

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F0684 SS = D	Continued from page 2 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 noted that 5 mg dispensed 7 tablet three times for a total of 21 tablets of 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 : 2.5 mg once and 5 mg three times. Further inquiry was made with the Director of Nursing on in the afternoon, who reported that despite the facility having an Emergency Drug kit, no tablets were removed from the E-Kit (emergency kit), and the facility did not have any other residents on and have not had any residents on in over a year. 2) An observation of medication administration for Resident # 2 was conducted on 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, 6.25 mg, 100mg, 1000 mg, 25 mg and 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 , which was held because the resident's was 109. However, upon medication reconciliation, the nurse documented on the medication administration record that she also had administered polyethylene 3350 powder, give 17 GM by twice daily for . Mix with 8 ounces of fluid. This medication was not administered during the observed medication administration. An interview was conducted with Staff A on 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	F0684	Continued from page 2 A. The Director of Nursing/Designee will conduct audits on 5 residents on weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. Audits will include medication administration accuracy, lab completion and follow up, physician notification compliance. The findings of these quality monitoring's to be reported to the quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105257	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED

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F0684 SS = D	Continued from page 3 medication from the other cart, when she administered the medication this morning, since none was available on this cart.	F0684		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug , ,); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: 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) in response to an elevated International Normalized Ratio (INR) for a resident who is receiving , 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 . , (Resident # 1). The findings included:	F0757	F0757 Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. this plan of correction is prepared and/or executed solely because it is required (1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A. On , resident #1 was discharged from facility to Lawnwood Regional Medical Center. B. As of , there are no residents on , . No additional residents were identified as negatively . (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; A. On , the Director of Nursing/Designee identified and reviewed current residents receiving , . the review included verification of current physician orders, review of /INR results and therapeutic ranges, confirmation of timely laboratory draws, and verification of appropriate medication and documentation. At the time of review, there were no residents in the facility receiving / , ; however, all other therapies were reviewed. Any discrepancies identified during the review were immediately corrected, including physician notification and clarification of orders. (3) What measures will be put into place or what systematic changes you will make to ensure A. By , License Nursing staff will have been educated by the Director of Nursing/Designee on the components of F757, including the use of the management protocol, documentation of indication and monitoring, appropriate response to laboratory results, and timely physician notification, with an emphasis on	

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F0757 SS = D	Continued from page 4 Review of the clinical record for Resident # 1 revealed the resident was admitted to the facility on with a diagnosis of , valve. The physician prescribed for the resident to receive 5 mg and to have /INR monitoring. Further review of the results of /INR (Prothrombin/International Normalized Ratio) for Resident # 1 revealed the following: The labs drawn for /INR are noted as invalid. On the /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 the /INR revealed a PROTHROMBIN TIME 180.0 SECS and an INR of 17.63 RATIO. The physician also prescribed on for the resident to have additional /INR lab test completed for 2 days on Saturday, and Sunday , however they were not done. The /INR was not done until Monday, . 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 which documented a valve, presented with today. Her history includes , , , , and recurrent . She was found to have a critically elevated INR of 17.63 and 180 was held, and K was administered. Labs completed this am INR/ pending results. Will continue to monitor closely. The note further documented an Assessment: requiring fluid replacement. Plan: 75 ml for " A practitioner noted on "Patient is lying in bed awake but is drowsy and . 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 and are well controlled. Patient has no behavioral outbursts." The Director of Nursing documented a progress note on at 5:00 PM, "Writer met with resident's son, husband and sister-in-law at bedside to discuss current POC. management discussed and they were informed of medication	F0757	Continued from page 4 avoidance of unnecessary drugs and compliance with monitoring requirements for . B. Newly hired license nursing staff will receive education by the Director of Nursing/Designee on the components of F757, including the use of the management protocol, documentation standards, critical lab value reporting and escalation processes, and physician communication expectations during orientation as part of the facility's systematic changes. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, ie., what quality assurance program will be put in place: A. The Director of Nursing/designee will conduct monitoring audits weekly for 4 weeks, then biweekly for 4 weeks, and monthly x 1 month. Audits will review appropriate drug use, compliance with laboratory monitoring, timely physician notification, and accuracy of documentation. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	

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F0757 SS = D	Continued from page 5 error related to it. They verbalized understanding of same and all questions addressed. Resident currently , and non-verbal which was discussed with family and ARNP. Initial phone orders received to have STAT , CMP, and vs hospital transfer but family opted in for transferring to hospital. Resident , 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 , the physician prescribed on for the resident to receive 5 mg by every other day beginning . The physician also prescribed for /INR lab to be drawn. Then on at 5:23 PM, the physician prescribed to hold pending /INR results. On , the nurse noted that the results of the /INR were received and the physician was contacted. The physician prescribed for the resident to receive 2.5 mg on and to resume 5.0 mg daily on . Review of the Medication Administration record for Resident # 1 revealed that the nurses placed their initials in the appropriate box to indicate that the 2.5 mg was administered on and 5.0 mg was administered on , and . Further review of the physician orders revealed that the 5 mg was placed on hold to and to . The nurse documented that she administered this medication on . The 5.0 mg administered on and , the nurse documented that the resident's INR was 3.38. Additionally, the 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 . On the physician was contacted when the INR was again noted as critically elevated at 17.63, the physician prescribed for the resident to received K 10 mg , injection and to have the /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 . However, by this time, the resident's condition has changed and deteriorated,	F0757		

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F0757 SS = D	Continued from page 6 requiring additional intervention and eventual transfer to the hospital for further evaluation on . An interview was conducted on at 2:30 PM with the Director of Nursing, who confirmed the labs were not drawn on and . The labs were not drawn until . She further confirmed there is no evidence that the nurses contacted the physician before noting they administered the 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 on 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.	F0757		

Florida Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10040953	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIATA AT SAINT LUCIE	611 S 13TH ST , FORT PIERCE, Florida, 34950

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N0000	INITIAL COMMENTS An unannounced licensure complaint survey for complaint number 2026003505, 2026003651, and 2026004646 was conducted on and at Aviata at St. Lucie. The facility had deficiencies at the time of survey.	N0000		
N0054 SS = D	Follow Physician Orders CFR(s): 59A-4.107(5), FAC All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical and administration review, and interview, the facility failed to follow accepted standards of practice ensure the nursing staff followed the prescribed physician orders and adhered to professional standards for medication administration. This failure affected 2 of 6 sampled residents (Resident # 1 and Resident # 2). "Professional standards of quality" means that care and all services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a clinical discipline or in a specific clinical situation or setting. The findings included: 1) Review of the clinical record for Resident # 1 revealed that the resident was admitted to the facility on with diagnoses which included , valve. History of valve replacement and , , , . The physician prescribed on for the resident to receive 5 mg by every other day beginning . The physician also prescribed for /INR lab to be drawn. Then on at 5:23 PM, the physician prescribed to hold pending /INR results. On , the nurse noted that the results of the /INR were received and the physician was contacted. The physician prescribed for the resident to receive	N0054	N0054 Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. this plan of correction is prepared and/or executed solely because it is required (1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A. On resident #1 was discharged from facility to Lawnwood Regional Medical Center. B. On Physician was notified of prior events and current conditions for resident discharged to Lawnwood Regional Medical Center on . No additional residents were affected at this time. C. On , comprehensive medication and lab review for resident #1 was completed to ensure all physician orders are current and being followed; resident transferred to hospital prior to additional interventions being implemented. D. As of , the licensed nursing staff identified in the deficient practice are no longer employed by the facility. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; A. On , the Director of Nursing/Designee identified and reviewed current residents receiving , , . The review included	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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N0054 SS = D	Continued from page 1 2.5 mg on and to resume 5.0 mg daily on . Review of the Medication Administration record for Resident # 1 revealed that the nurses placed their initials in the appropriate boxes to indicate that the 2.5 mg was administered on and 5.0 mg was administered on , and . Further review of the physician orders revealed that the 5 mg was placed on hold to and to . However, the nurse documented that the resident's INR was 3.38 on and . Additionally, the 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 . On when the INR was noted as critically elevated at 17.63, the physician prescribed for the resident to received K 10 mg injection and to have the /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 . 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 . Further review of the results of /INR for Resident # 1 revealed the following: The labs drawn for /INR are noted as invalid. - /INR - PROTHROMBIN TIME 94.9 SECS (normal range 9.6 - 12.6) HH INR 9.12 RATIO (normal range - 0.87 - 1.13) HH - /INR - PROTHROMBIN TIME 180.0 SECS - HH INR 17.63 RATIO HH Review of the Medication Administration Record (MAR) revealed multiple entries for Oral Tablet 5 MG on , , and : 2.5 mg on . An interview was conducted on at 2:30 PM with the Director of Nursing, who confirmed the labs were not drawn on . and . The labs	N0054	Continued from page 1 verification of current physician orders, review of /INR results and therapeutic ranges, confirmation of timely laboratory draws, and verification of appropriate medication and documentation. At the time of the review, there were no residents in the facility receiving / ; however, all other therapies were reviewed. Any discrepancies identified during the review were immediately corrected, including physician notification and clarification orders. (3) What measures will be put into place or what systematic changes you will make to ensure A. By , the facility implemented system changes, including the establishment of an Management Protocol outlining INR critical value parameters, required interventions for elevated INR levels, and mandatory physician notification guidelines. A Lab Tracking Log was also implemented to ensure all ordered laboratory tests are completed as scheduled, reviewed in a timely manner, and escalated appropriately when not obtained. In addition, High-Risk Medication Audits Tool for , was put into place to monitor compliance and medication safety practices. Education was completed with licensed nursing staff regarding the administration, monitoring, management of / , including therapeutic INR ranges, timely physician notification, documentation requirements, and appropriate interventions for abnormal lab values. B. By , Licensed Nursing Staff will have been educated by Director of Nursing/designee on the components of N0054 with an emphasis on medication administration safety, documentation accuracy, and appropriate clinical decision-making and escalation protocols. C. Newly hired licensed nursing staff will receive education by the Director of Clinical/Designed on the components of N0054 with an emphasis on medication administration safety, documentation accuracy, and appropriate clinical decision-making and escalation protocols. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: (A) The Director of Nursing/Designee will conduct audits on 5 residents on weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1	

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AVIATA AT SAINT LUCIE	611 S 13TH ST , FORT PIERCE, Florida, 34950

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N0054 SS = D	Continued from page 2 were not drawn until . She further confirmed there is no evidence that the nurses contacted the physician before noting they administered the 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 on 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. The surveyor questioned why the resident's /INR level continued to elevate despite the nurse documenting that the medication was on hold, therefore the surveyor requested pharmacy records to determine what medication was administered. According to the dispensary records for Resident # 1, the pharmacy records noted that 5 mg dispensed 7 tablet three times for a total of 21 tablets of 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 2.5 mg once and 5 mg three times. Further inquiry was made with the Director of Nursing on in the afternoon, who reported that despite the facility having an Emergency Drug kit, no tablets were removed from the E-Kit (emergency kit), and the facility did not have any other residents on and have not had any residents on in over a year. The nurses who placed their initials to indicate they administered the medication are not available to be interviewed. 2) An observation of medication administration for Resident # 2 was conducted on 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, 6.25 mg, 100mg, 1000 mg, 25 mg and 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 , which was held because the resident's was 109. However, upon medication reconciliation, the nurse documented on the medication administration record that she also had administered polyethylene 3350 powder, give 17 GM by twice daily for . Mix with 8 ounces of fluid.	N0054	Continued from page 2 month. Audits will include medication administration accuracy, lab completion and follow up, physician notification compliance. The findings of these quality monitoring's to be reported to the quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10040953	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIATA AT SAINT LUCIE	611 S 13TH ST , FORT PIERCE, Florida, 34950

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N0054 SS = D	Continued from page 3 This medication was not administered during the observed medication administration. An interview was conducted with Staff A on 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. Class III	N0054		
N0201 SS = D	Right to Adequate and Appropriate Health Care CFR(s): 400.022(1)(l), FS (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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 evidence by the facility failing to follow the prescribed monitoring, medication administration and accurate documentation for 1 of 1 sampled resident (Resident #1) who are prescribed . The findings included: Review of the clinical record for Resident # 1 revealed that the resident was admitted to the facility on with pertinent diagnosis of , valve. Further review of the physician orders revealed that the physician prescribed on ( ) 5 mg by	N0201	N0201 Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies, this plan of correction is prepared and/or executed solely because it is required (1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A. On , resident #1 was discharged from facility to Lawnwood Regional Medical Center. B. As of , there are no residents on . No additional residents were identified as negatively . (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; A. On , the Director of Nursing/Designee identified and reviewed current residents receiving . the review included verification of current physician orders, review of /INR results and therapeutic ranges, confirmation of timely laboratory draws, and verification of appropriate medication and documentation. At the	

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N0201 SS = D	Continued from page 4 every other day for valve replacement to begin on and she prescribed for labs for (/INR), with diff and comprehensive panel (CMP). However, the labs drawn for /INR are noted as invalid. Then on at 5:23 PM, the physician prescribed to hold pending /INR results. On , the nurse noted that the results of the /INR were received and the physician was contacted. The physician prescribed for the resident to receive 2.5 mg on and to resume 5.0 mg daily on . Review of the Medication Administration record for Resident # 1 revealed that the nurses placed their initials in the appropriate boxes to indicate that the 2.5 mg was administered on and 5.0 mg was administered on , and . Further review of the physician orders revealed that the 5 mg was placed on hold to and to . However, the nurse documented that the resident's INR was 3.38 on and . Additionally, the 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 to gain guidance regarding administration of the . On when the INR was noted as critically elevated at 17.63, the physician prescribed for the resident to received K 10 mg injection and to have the /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 . 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 . Review of the Medication Administration Record (MAR) revealed multiple entries for Oral Tablet 5 MG on , , and : 2.5 mg on . An interview was conducted on at 2:30 PM with the Director of Nursing, who confirmed the labs were not drawn on and . The labs were not drawn until . She further confirmed there is no evidence that the nurses contacted the physician before noting they	N0201	Continued from page 4 time of review, there were no residents in the facility receiving / , , ; however, all other therapies were reviewed. Any discrepancies identified during the review were immediately corrected, including physician notification and clarification of orders. (3) What measures will be put into place or what systematic changes you will make to ensure A. By , License Nursing staff will have been educated by the Director of Nursing/Designee on the components of N0201, including the use of the management protocol, documentation of indication and monitoring, appropriate response to laboratory results, and timely physician notification, with an emphasis on avoidance of unnecessary drugs and compliance with monitoring requirements for . B. Newly hired license nursing staff will receive education by the Director of Nursing/Designee on the components of N0201, including the use of the management protocol, documentation standards, critical lab value reporting and escalation processes, and physician communication expectations during orientation as part of the facility's systematic changes. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, ie., what quality assurance program will be put in place: A. The Director of Nursing/designee will conduct monitoring audits weekly for 4 weeks, then biweekly for 4 weeks, and monthly x 1 month. Audits will review appropriate drug use, compliance with laboratory monitoring, timely physician notification, and accuracy of documentation. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	

Florida Agency for Health Care Administration

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N0201 SS = D	Continued from page 5 administered the 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 on 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 noted that 5 mg dispensed 7 tablet three times for a total of 21 tablets of 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 : 2.5 mg once and 5 mg three times. Further inquiry was made with the Director of Nursing on in the afternoon, who reported that despite the facility having an Emergency Drug kit, no tablets were removed from the E-Kit (emergency kit), and the facility did not have any other residents on and have not had any residents on in over a year. Class III	N0201		