STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105394	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at the Palms	2600 Highlands Blvd N Palm Harbor, FL 34684

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the physician was notified of blood sugar levels (BSLs) that were outside parameters for one (Resident #2) of two residents sampled.Findings included:Resident #2 was readmitted to the facility on [DATE] with diagnoses to include type 2 diabetes mellitus with hyperglycemia, and type 2 diabetes with diabetic peripheral angiopathy without gangrene and long-term use of insulin.Review of Resident #2's Medication Administration Record (MAR) for January 2026 revealed Novolog FlexPen subcutaneous solution pen-injector 100 UNIT/ML (milliliters) (insulin Aspart). Inject per sliding scale: 150-200 + 4 Units; 201-250 = 6 units; 251-300 = 8 units; 301-350 = 10 units; 351-400 units = 12 units. Notify MD (medical doctor) if BS (blood sugar) less than 70 or greater than 400; 401-450 = 14 units subcutaneously before meals and at bedtime related to type 2 diabetes mellitus with hyperglycemia. Start date 10/29/25. D/C (discontinued) date 1/26/26.The order revealed the physician was to be notified for any BS readings above 400.Review of Resident #2's MAR for January 2026 revealed the following BS readings:On 1/1 at 9:00 p.m. = 420On 1/ 2 at 9:00 p.m. = 423On 1/4 at 9:00 p.m. = 409On 1/6 at 4:30 p.m. = 440On 1/8 at 9:00 p.m. = 450On 1/11 at 9:00 p.m. = 412On 1/18 at 9:00 p.m. = 408On 1/21 at 11:30 a.m. = 413On 1/23 at 4:30 p.m. = 436Review of Resident #2's MAR for December 2025 revealed Resident #2 had BS readings above 400 19 out of 120 tested times.Review of Resident #2's MAR for November 2025 revealed Resident #2 had BS readings above 400 32 out of 120 tested times.Review of Resident #2's medical record from November 2025 to January 2026 did not revealed documentation the physician being notified of BS readings above 400 per orders.On 2/23/2026 at 5:20 p.m. an interview was conducted with the Director of Nursing (DON). The DON reviewed the MARs for Resident #2 and stated the nurses should have been documenting notification of the BS levels that were above 400. She stated sometime in October the physician changed the sliding scale to include higher numbers because the resident was at baseline with the higher numbers. She stated when they changed the order to increase the sliding scale to 450, he did not change the instructions. The DON stated given the way the current orders read, They should have documentation. The DON stated if the numbers were above or below parameters, the physician should be notified.Review of a facility policy titled, Notification of Change, revised 12/16/2020, showed, policy - The Center to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is a change in the status or condition.Procedure: The nurse to notify the attending physician and Resident Representative when there is a(n):o Accidentso Significant change in the patient/resident's physical, mental, or psychosocial statuso Need to alter treatment significantly? New treatment? Discontinuation of a current treatment due to but not limited to: Adverse consequences, Acute condition, Exacerbation of a chronic condition.o A transfer or discharge of the Patient/Resident from the Centero Patient/Resident consecutively refuses medication and/or treatment (i.e. two or more times)o Patient/Resident is discharged without proper medical authority (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In the event of an emergency situation, 911 to be called and the attending physician and the Resident Representative to be notified as soon as possible. The nurse to complete an evaluation of the Patient/Resident. Document evaluation in the medical record. The nurse will contact the physician. In the event that the attending physician does not respond in a reasonable amount of time, the Medical Director may be contacted. If the Medical Director does not respond, call 911 and document in the medical record. Notify the patient/resident and the resident representative of the change in condition. Document notification in the medical record. Document resident/patient change in condition on 24 Hour Report Complete SBAR as indicated.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure a resident with contractures received care and services to prevent on-going decline in physical abilities and deconditioning for one (Resident # 1) of one resident observed. Findings include:On 02/23/2026 at 9:45 AM Resident #1 was observed lying in bed right hand was observed with fingers touching palm, no splint or support. On 02/23/2026 at 12:14 PM Resident #1 was observed lying in bed. He was unable to verbally communicate but able to shake his head when asked questions. His right hand was observed with fingers touching palm, with no splint or support.On 02/23/2026 at 2:00 PM Resident #1 was observed lying in bed. His neck pillow was observed lying on top of the sheet over the stomach. The right hand was observed with fingers touching palm with no splint or support.Review of Resident #1's admission Record revealed an admission to the facility initially on 10/09/2025 and readmitted on [DATE] with diagnoses to included but not limited to unspecified displaced fracture of surgical neck of right humerus, subsequent encounter fracture with routine healing, Type 2 Diabetes Mellitus without complications, affecting right dominant side, functional quadriplegia.Review of Resident #1's Minimum Data Set (MDS) dated [DATE] revealed Resident #1 has impairments on one side of his upper and lower extremity and has no mobility devices.Review of Resident #1's Therapy Funding Verification Form, dated 2/23/2026, revealed Resident #1 was approved minutes for Physical and Occupational Therapy, per discipline for 30 minutes times, three visit for four weeks.On 02/23/2026 at 2:15 PM an interview was conducted with Staff A, License Practical Nurse, (LPN), Staff A stated Resident #1 is not receiving range of motion or routine care from nursing for his contracted hand, therapy is usually responsible for contractures. Staff A stated to her knowledge when a resident has any kind of contracture therapy screens the residents first. Then therapy will either continue the resident on therapy services or refer them to restorative therapy.On 02/23/2026 at 2:30 PM an interview was conducted with Staff B, Restorative Therapy. Staff B stated Resident #1 is not on her case load for restorative therapy. Staff B stated when therapy refers a resident for restorative, therapy will put the information in the electronic medical record. Staff B, Restorative Therapy stated checking the system daily for any changes to the schedule. Staff B stated Resident #1 was never referred to restorative therapy.On 2/23/2026 at 2:40 PM an interview was conducted with the Rehab Director. The Rehab Director stated he has not screened resident #1 for his contracted hand. The Rehab Director stated nursing is responsible for managing Resident #1 contracted hand.On 02/23/2026 at 4:04 PM an interview was conducted with the Director of Nurses, (DON). The DON said Resident #1 was admitted with right hand contracture. The DON stated nursing cannot do anything for a resident's contracted hand. Nursing would only take over splint management once therapy has done an evaluation and provides education to nurses on how to safely manage the resident's hand.Review of the facility policy titled, Contractures, Prevention dated 11/30/2014, revealed: Policy: Each resident must be evaluated for need of contracture prevention procedures on admission, readmission and as needed. Procedure. RANGE of Motion: Resident with inactive extremities should have range of motion done to those extremities as part of their daily care.