

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105558	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER Aviata at West Palm Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 5065 Wallis Road West Palm Beach, FL 33415	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure timely and appropriate care and services for 5 of 27 sampled residents as evidenced by the failure to provide wound care for non-pressure wounds for Residents #9, #76, and #110; failure to complete weekly skin assessments for Residents #9, #76, #110 and #10; failure to provide supplies and treat edema as ordered for Residents #76 and #110; and failure to administer medications as ordered for Resident #13. The findings included: 1) Review of the record revealed Resident #9 was readmitted to the facility on [DATE] with diagnoses to include Diabetes, Morbid Obesity, Congestive Heart Failure, and Non-Pressure Chronic Ulcer of the Right Lower Leg. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 12, on a 0 to 15 scale, indicating the resident had moderate cognitive impairment. a) Review of the current physician ordered wound care dated 08/27/25 documented the need for daily wound care for Resident #9's right lower extremity. Review of the current Treatment Administration Record (TAR) for September 2025 lacked the provision of wound care on 09/12/25, 09/13/25, 09/20/25, and 09/21/25, as evidenced by the blank areas in the TAR and lack of the nurses' initials. During an observation and interview on 09/22/25 at 3:38 PM, a dressing was noted on the lower right leg of Resident #9. When asked about the provision of wound care by the nurses, the resident stated the dressing was changed daily, except on weekends. An interview was conducted on 09/24/25 at 4:08 PM with the Director of Nursing (DON) and the Wound Care Nurse. The Wound Care Nurse stated she worked Monday through Friday and was responsible for all wound care during the week. The Wound Care Nurse stated during the weekends, the nurse on duty should provide the wound care in her place. When asked when she returned after the weekends if the wound care had been completed, the Wound Care Nurse replied, Yes, it is. The DON interjected that the facility had hired a fifth nurse to help cover the weekends for the last two months to ensure that wound care and other responsibilities would be completed. The DON stated that sometimes the wound care had not been done. During this interview, a side-by-side review of the September 2025 TAR for Resident #9 was completed. The DON and the Wound Care Nurse were shown the missing days of treatment for Resident #9. The Wound Care Nurse stated that Resident #9 would only allow her to treat his wound. When asked where a resident's refusal would be documented, both the DON and Wound Care Nurse replied that it would be in a nurse's progress note and in the TAR. Both the DON and Wound Care Nurse were unable to locate any refusal of wound care treatment by Resident #9. The DON and Wound Care Nurse agreed with the findings for the lack of wound care treatments. b) Upon further review of the record, a current physician order dated 04/15/25 documented staff were to complete weekly skin sweeps. Review of the September 2025 TAR for Resident #9 lacked this (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order. Review of the Weekly Skin Integrity Reviews revealed the last weekly skin assessment for Resident #9 was completed on 07/15/25. During an interview on 09/24/25 at 12:04 PM, when asked who performed the weekly skin sweeps, Staff K, Licensed Practical Nurse (LPN), stated she completes them and documents them on the TAR. During the continued interview on 09/24/25 at 4:08 PM, the DON was made aware of the lack of documented weekly skin sweeps and had no response. 2) Review of the record revealed Resident #76 was admitted to the facility on [DATE] with a readmission on [DATE], with diagnoses to include a right arm fracture, a left leg fracture, and Morbid Obesity. Review of the current MDS assessment dated [DATE] documented the resident had a BIMS score of 14, on a scale of 0 to 15, indicating the resident was cognitively intact. a) Review of the current physician orders included daily wound care for Resident #76's left knee as of 08/01/25 and an order for daily wound care to the resident's left lower leg as of 09/15/25. Review of the August 2025 TAR revealed the wound care for the left knee was not completed on 08/08/25, 08/19/25, and 08/25/25. Review of the September 2025 TAR revealed the same wound care was not completed on 09/11/25, 09/12/25, 09/20/25, and 09/21/25. The September 2025 TAR also revealed the left lower leg wound care was not completed on 09/20/25 and 09/21/25. An observation on 09/22/25 at 11:46 AM revealed one dressing to the left leg of Resident #76 dated 09/19/25. Photographic evidence obtained. An observation on 09/24/25 at 11:59 AM revealed one dressing to the left leg of Resident #76 dated 09/22/25. During the continued interview on 09/24/25 at 4:08 PM, the Wound Care Nurse clarified there was just one wound to Resident #76's left leg. During a side-by-side review of the record, the DON and Wound Care Nurse were made aware of the lack of wound care as per the August and September 2025 TARs and agreed with the findings. b) Further review of the record revealed the order for weekly skin sweeps every Saturday as of 08/16/25. Review of the September 2025 TAR documented the skin sweeps were completed on 09/13/25 and 09/20/25, as evidenced by a checkmark, but the record lacked the Weekly Skin Integrity Review assessments for these dates. During the interview on 09/24/25 at 4:08 PM, the DON confirmed the weekly skin sweeps were to be documented on the TAR as completed, and the nurse was to also complete the Weekly Skin Integrity Reviews to document the specifics of the assessment. The DON was again made aware of the lack of completed skin sweeps. c) Further review of the record revealed a physician order dated 09/18/25 for the use of compression stocking for Resident #76. Staff were to apply the compression stockings every morning and remove them at bedtime. Observations on both 09/22/25 at 11:46 AM and on 09/24/25 at 11:59 AM lacked any compression stockings being worn by Resident #76. During an interview on 09/24/25 at 4:59 PM, when asked if he was aware of or offered any special socks, Resident #76 stated he had never been offered any socks. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/24/25 at 5:04 PM, when asked if she was aware of the ordered compression stockings for Resident #76, Staff P, Certified Nursing Assistant (CNA) replied, No more socks, no special socks. During an interview on 09/24/25 at 5:15 PM, when asked if she was aware of the physician ordered compression stockings for Resident #76, Staff K, LPN, initially denied any orders for the stockings. The LPN reviewed the current orders and then confirmed the order for the compression stockings. The LPN stated she had been off for a few days, and the order came in while she was gone. 3) Review of the record revealed Resident #110 was admitted to the facility on [DATE]. Review of the BIMS Evaluation dated 09/04/25 documented the resident had a score of 14 indicating he was cognitively intact. a) Review of the current physician orders documented nursing was to provide daily wound care to the resident's bilateral lower extremities as of 09/15/25. Review of the corresponding September 2025 TAR revealed the ordered wound care was not provided on 09/11/25, 09/12/25, 09/13/25, 09/20/25, and 09/21/25. During an observation on 09/22/25 at 4:09 PM Resident #110 was noted with bilateral leg dressings dated 09/22/25. When asked about the frequency of wound care, Resident #110 stated the dressings hadn't been changed the past four days. During the continued interview on 09/24/25 at 4:08 PM the DON and Wound Care Nurse reviewed the September 2025 TAR and agreed with the findings. b) Review of the current orders revealed staff were to apply bilateral compression stocking from 09/11/25 through 09/18/25 to Resident #110's legs. The order was changed on 09/18/25 to apply bilateral Ace wraps daily in the morning and to remove at bedtime. Review of the corresponding September 2025 TAR lacked any documentation related to the compression stockings. Further review revealed the Ace wraps had not been applied on 09/21/25, 09/23/25, and 09/24/25. During an observation on 09/22/25 in the morning, Resident #110 was noted with bilateral lower extremity edema (swelling) as his jeans were tight against his legs. A second observation on 09/22/25 at 4:09 PM revealed Resident #110 wearing shorts. His legs were bare and remained very swollen with no compression stockings or Ace wraps noted. During an interview at this time, Resident #110 voiced concern about his swollen legs and the lack of Ace wraps. The resident stated he used Ace wraps in the past, but they got old and were thrown away. Resident #110 was unsure how long ago they had been thrown away. During a supplemental observation on 09/23/25 at 3:56 PM, Resident #110 had just returned to the facility after a short leave of absence and again was not wearing any Ace wraps. During an interview on 09/24/25 at 5:04 PM, when asked about any wraps for Resident #110's legs, Staff P, CNA, stated she was unaware of any type of leg wraps. During an interview on 09/24/25 at 5:15 PM, when asked about the Ace wraps for Resident #110, Staff K, LPN, stated he had them on earlier that day, but they had gotten wet and were removed just prior to leaving the facility. The Assistant Director of Nursing (ADON) approached, and during a (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication administration record, she stated, Either one. When asked how the nurse knows when to do the skin assessment, she stated, There is an order. When asked does the order specify the day the skin assessment should be done, she stated, Yes. At that time, the UM was made aware that skin assessments were not being done on several residents that had an order. b) Review of a physician order dated 08/19/25 instructed staff to administer Midodrine HCl Oral Tablet 5 MG (Midodrine HCl) Give 1 tablet via PEG-Tube three times a day for hypotension, give if SBP (top number of blood pressure) is less than 110. Review of the September Medication Administration Record (MAR) revealed that staff had administered the midodrine HCL 5mg on 9/2/25, 09/04/25, 09/05/25, 09/06/25, 09/11/25, 09/16/25, 09/20/25, 09/21/25 when the SBP was greater than 110. 5) Record review for Resident # 13 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Chronic Obstructive Pulmonary Disease, a condition caused by damage to the airways or other parts of the lung, Low Back Pain, Unspecified Dementia, a medical term used for memory loss and confusion, but the cause of the decline cannot be determined and Age Related Osteoporosis without pathological fracture, a condition of progressive bone loss and reduced bone strength due to aging, which increases the risk of future fractures, but in the absence of a current fracture. Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed that Resident # 13 had a Brief Interview for Mental Status of 14, which indicated that she was cognitively intact. Review of the Provider Note dated 09/11/25 documented the resident is to be started on Fosamax. Review of the Physician's Orders showed that Resident #13 had an order dated 09/11/25 for Fosamax Oral Tablet 70 mg every day in the morning. Review of the electronic medication administration record (MAR) revealed that the medication had been administered from 09/12/25 to 09/23/25. During an observation conducted on 9/24/2025 at 3:30 PM the resident was awake and alert watching TV. She doesn't remember going to a doctor's appointment last month. She stated that she does not have any pain and is able to adjust herself in bed. The call light was noted to be clipped on the resident's bed. During an interview conducted on 09/24/25 at 4:00 PM with surveyor colleague and Staff D, Unit Manager (UM), when asked for the phone number of the provider who placed the order for Fosamax on 09/11/25 she stated that the provider was no longer with the facility as of last Friday and that another provider had taken over the assignment. The UM was asked to review the orders for Fosamax, and she stated that this is not a new order, it was a time change. She stated that it appeared that the time was changed to 3:00 AM TO 6:00 AM from 7:00 AM TO 11:45 AM. She stated that the pharmacy calls the unit if there are any issues with an order. When asked to clarify if the order was for daily or weekly administration the UM called the provider via speaker phone, and he stated that the medication is a weekly dose and changed it in the system as the phone call was in progress. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the conversation, Staff Nurse F was at the nurse's station and said she never gave this medication and was talking to pharmacy to adjust the time of administration. During a side-by-side review of the MAR with the UM there was documentation that the nurse had administered the medication. During an interview conducted on 9/25/25 at 9:07 AM with the Consultant Pharmacist (CP) and the Director of Nursing (DON), the CP provided documentation for the original order on 9/11/2025 with an alert that was sent to the provider to clarify frequency. Usually given once a week. She stated the order was never filled by pharmacy or dispensed to the facility. The order was cancelled on 09/24/2025 and re-entered with the correct frequency and time to start on Saturday 09/27/2025. The DON addressed the documentation in the Medical Administration Record (MAR) that showed administration of Fosamax from 09/12/25 to 09/23/25 and is currently working on a Performance Improvement Plan (PIP) and will follow-up with nursing regarding the MAR documentation.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interviews, the facility failed to provide care and services for a pressure ulcer as evidenced by not following physician orders to treat a facility acquired pressure ulcer for 1 of 2 sampled residents (Resident #10).The findings included:Record review revealed Resident #10 was admitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE], documented a Brief Interview Mental Status (BIMS) score of 99 on a 0-15 scale indicating severe cognitive impairment.Review of the quarterly care plan dated 08/16/25 revealed a focus that Resident #10 had skin impairment to the sacrum with a goal to promote healing with intervention of staff to administer treatments as ordered and monitor for effectiveness. Review of a wound care consultation note dated 07/03/25, documented that Resident #10 had an unstageable pressure ulcer to her sacrum that measured 5.5cm x 5.0cm x 0.2cm with 90% necrotic tissue.Review of a physician order dated 08/16/2025 instructed staff to cleanse sacrum wound with normal saline or Dakin's (antibiotic wound cleanser) half strength, apply Santyl (debriding ointment) to wound bed, fill depth with gauze and cover with silicone superabsorbent border dressing every day at 12:00 PM. A second physician order dated 09/19/25 instructed staff to cleanse sacrum wound with normal saline or wound cleanser, apply collagen and calcium alginate rope and cover with silicone superabsorbent border dressing every day at 12:00 PM.During observation of wound care on 09/24/25 at 10:55 AM, The Wound Care Nurse prepared her supplies and donned her gown and gloves. Staff M, Certified Nursing Assistant (CNA) was present at bedside to assist with turning Resident #10. The Wound Care Nurse removed a beige colored dressing from the sacrum wound. The dressing removed was not dated and it was soiled with a moderate amount of serosanguinous (pink, yellow) drainage; there was redness surrounding the wound and the wound appeared to be the size of a quarter with depth. The wound care nurse cleansed the wound with wound cleanser, applied collagen powder to the wound bed and packed with calcium alginate rope and covered with silicone superabsorbent border.During an interview on 09/24/25 at 11:32 AM, When asked did you provide wound care to Resident #10 on 09/23/25, she stated No, I left early yesterday. When asked was there someone else scheduled to do wound care she stated Yes, the Unit Manager.Review of the August and September Treatment Administration Record (TAR) revealed that wound care was not provided to Resident #10 on 08/08/25, 08/16/25, 08/19/25, 09/11/25, 09/12/25 and 09/23/25.		

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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. Based on observations, interviews and record reviews, the facility failed to provided care and devices in order to prevent a decrease in range of motion for 1 of 1 resident reviewed for position/mobility, Resident #23. The findings included:Record review for Resident #23 revealed an admission date of 11/29/24. According to the resident's most recent complete assessment, a Quarterly Minimum Data Set (MDS), with a reference date of 08/28/25, Resident #23 was not assessed for cognition due to 'resident is rarely/never understood'. The assessment documented that Resident #23 was dependent upon staff for all Activities of Daily Living (ADLs). Resident #23's diagnoses at the time of the MDS included: Anemia, Coronary Artery Disease, Diabetes Mellitus, Aphasia, Non-Alzheimer's dementia, Seizure disorder, Respiratory failure, Aphasia following Cerebrovascular accident, Dysphagia, Gastro Esophageal Reflux Disease (GERD), Contracture of left elbow. Resident #23's orders included:Restorative: Left elbow splint, 8hrs as tolerated - 11/30/24.Further review of resident's record revealed no additional orders for range of motion, devices, braces or splints. Resident #23's care plan documented, Alteration in Usual Functional Performance in Mobility/Transfer status related to CVA and left elbow contracture Date Initiated: 06/02/2025 Revision on: 06/02/2025 The goal of the care plan was documented as, Resident's Functional Performance in transfer/mobility status will maintain at current functioning level through next review date. Date Initiated: 06/02/2025 Target Date: 11/15/2025. There were no interventions to prevent contracture or further decrease in range of motion. Resident #23's care plan for pain documented, The resident has acute/chronic pain. -Chronic Physical Disability, -Contractures, -Muscle weakness Date Initiated: 01/13/2025 Revision on: 01/13/2025. The goal of the care plan was documented as, The resident will have minimal interruption in normal activities due to pain through the review date. Date Initiated: 01/13/2025 Target Date: 11/15/2025. There were no interventions to prevent contracture or a decrease in range of motion On 09/23/2025 at 7:16 AM, Resident #23 was observed in bed with his left hand noted to have fingers contracted and hand folded at the base of the fingers and palm of the hand. On 09/24/2025 at 7:56 AM, Resident #23 was observed in bed awake with his left hand noted to have fingers contracted and hand folded at the palm and his right hand contracted into a fist. During an interview, on 09/24/25 at 2:39 PM with Staff A, CNA, when asked about splints and devices for Resident #23's contractures, Staff A stated that Staff B, does the braces. During an interview, on 09/24/25 at 2:47 PM, with the Certified Occupational Therapist Assistant (COTA), when asked about Resident #23 being assessed for Range of motion devices, the COTA stated, he was on caseload 12/05/24 to 12/23/24 for Occupational therapy for a palm guard for left upper extremity. The palm guard was discontinued due to a hand wound on 12/2324. He was supposed to have a T-bar for the right upper extremity that never came in according to the discharge note. The therapy director recommended it 12/05/24.The COTA acknowledged that staff did not follow up with the resident after the wounds had healed and did not make any additional attempts to obtain the splint for the right upper extremity that did not come in after being ordered. During an interview, on 09/24/25 at 2:59 PM with the Assistant Director of Nursing (ADON), when asked about Resident #23 having any device to prevent contracture and to prevent further decrease in range of motion in Resident #23's extremities, the ADON replied, I just spoke with the aide and they said that they (therapy) didn't give him a splint. The usually give the Restorative aide the splints. A while back, he was on palm protectors and he got blisters from them. Therapy re-evaluated him and I don't know why they didn't give him any splints back. He has recurring water blisters. During an interview, on 09/25/25 at 2:33 PM, with Staff B Restorative CNA, when asked about Resident #23 having any device to prevent contracture and to prevent further decrease in range of motion, Staff B replied, We never got the order, it would have been in my splint book. Staff B further stated that there were no orders from therapy that included any such devices.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a Reacher for 1 out of 1 resident reviewed for Accidents (Resident #13). The findings included: Record review for Resident # 13 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Chronic Obstructive Pulmonary Disease, a condition caused by damage to the airways or other parts of the lung, Low Back Pain, Unspecified Dementia, a medical term used for memory loss and confusion, but the cause of the decline cannot be determined and Age Related Osteoporosis without pathological fracture, a condition of progressive bone loss and reduced bone strength due to aging, which increases the risk of future fractures, but in the absence of a current fracture. Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed that Resident # 13 had a Brief Interview for Mental Status of 14, which indicated that she was cognitively intact. Review of Section GG of the MDS dated [DATE] revealed that Resident #13 required substantial/maximal assistance for movement and care. Review of the Physician's Orders showed that Resident #13 had an order dated 04/27/25 for Lumbar Spine Xray. An order dated 4/28/25 for Ortho Spine or Neurosurgeon appointment related to a fall and x-ray results and an order dated 05/06/25 for Neurosurgeon consult for lumbar spine compression fracture. Review of the Care Plan dated 04/27/25 and revised on 04/30/2025 documented that Resident # 13 had an actual fall without injury, and an alteration in musculoskeletal status compression fracture of L1. Interventions included but were not limited to anticipating and meeting needs, keeping call light within reach and encouraging the resident to call for assistance, bed in the lowest position, X-ray of lumbar region, and Reacher provided and encouraged to use. During an observation conducted on 09/22/25 at 11:46 AM, and 12:50 PM, and again on 09/24/25 at 12:37 PM, there was no Reacher visible in the room or on the resident's bedside table. The resident was asked if she had a device available to help her retrieve her belongings and she appeared unfamiliar with this device and said no. When asked if she knew how to request assistance from the staff, the resident responded, I press the button and pointed to the call bell. During an interview conducted on 09/25/25 at 10:00 AM with Staff G, Physical Therapy (PT) and Staff H, Occupational Therapy (OT) when asked to identify what is a Reacher, Staff H, OT showed this surveyor the device and stated that the facility orders and provides the resident if deemed necessary for use while in the facility. This is done by the OT Director if it is recommended. During a side-by-side review of the resident record, PT and OT services were discontinued on 12/20/2024 and there was no recommendation for a Reacher for this resident. During an interview conducted on 9/25/2025 at 11:20 AM with Staff I, CNA who is assigned to Resident #13 today. When asked if she saw a Reacher for the resident, Staff I escorted this surveyor back to the resident's room and looked in the closet which contained clothing and incontinent supplies. There was no Reacher in the closet. During an interview conducted on 09/25/25 at 11:40 AM with Staff F, Registered Nurse (RN), the nurse stated that she remembers the resident calling out after the fall. Resident #13 told me that she was reaching for her pants in the bedside table. The nurse stated that the resident is not a fall risk, they maintain her bed in a low position and keep her items within reach. When asked if the resident had a Reacher, the nurse said that she is not aware of any Reacher. During an interview conducted on 09/25/25 at 1:00 PM with the Staff J, MDS Coordinator she stated that a Reacher does not need to be ordered by the provider if it is care planned. Physical Therapy would do an evaluation and if deemed appropriate provide the Reacher. Staff J stated that she remembered the resident receiving one but not sure if it is still there. During an interview conducted on 09/25/25 at 2:45 PM with Staff D, Unit Manager, she stated that she is not sure if the resident had a Reacher but not sure that she has the cognition to use a Reacher. Review of the facility's Fall Investigation Form dated 04/27/25, had the following interventions: x-ray, Reacher (a device that enables a person to pick up (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Aviata at West Palm Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 5065 Wallis Road West Palm Beach, FL 33415	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	objects that are difficult to reach), and call bell within reach. During a side-by-side review of the Fall investigation packet with Associate Director of Nursing (ADON) on 09/25/25 at 4:21 PM, she confirmed that she attended the meeting. When asked who is responsible to follow up with the interventions, she stated that I am or the UM.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review, observations and interviews, the facility failed to provide treatment and services to prevent complications of enteral feeding (food delivered through a gastric tube) for 1 of 4 sampled residents as evidenced by failure to ensure aspiration (inhaling food or liquid in the airway) precautions for Resident #10 during enteral feeding. The findings included: Review of the facility policy titled Enteral Feeding-Enteral Nutrition Pump revised 11/12/18, documented in part Procedure: Assist resident to semi-Fowler_position (head and upper body raise 30-45 degrees) or turn on his or her right side. Record review revealed Resident #10 was admitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 99 on a 0-15 scale indicating severe cognitive impairment. Review of medical history revealed a diagnosis of stroke and dysphagia (difficulty swallowing). Review of the quarterly care plan dated 08/16/25 revealed a focus that Resident #10 was at risk of aspiration problems due to history of stroke and dysphagia with a goal the resident will have minimal risk of injury related to aspiration. Another focus documented that the resident required enteral feeding due to dysphagia and the resident will remain free of side effects or complications related to tube feeding and staff is to elevate the head of the bed during and after enteral feeding. An observation was conducted on 09/24/2025 at 9:15 AM, Resident #10 noted in bed lying on her back with the head of the bed completely flat and her mouth wide open. The enteral feed was infusing. Staff K, License Practical Nurse (LPN) was notified of Resident #10 being observed with the head of the bed flat. An observation was conducted on 09/24/2025 at 10:55 AM, Resident #10 was noted in bed lying on her back with the head of the bed completely flat. The enteral feed was infusing. The Wound Care Nurse was at bedside and made aware of the resident's head being flat while enteral feed infusing and the risk of the resident aspirating. She stated, The resident's sister likes her head this way. There was a note posted, by the family, on the wall above the resident's bed, that said to ensure staff elevate the head of the bed 30 to 45 degrees to assist with breathing. During an interview on 09/24/2025 at 11:20 AM, Staff K, LPN was made aware Resident #10's head was again observed completely flat with the enteral feed infusing. She stated, Again, the doctor said her head should be elevated 90 degrees due to risk of aspirating. Staff K, LPN went to resident's room and observed the resident with her head lying flat. Staff M, Certified Nursing Assistant (CNA) was at the bedside. Staff K, LPN educated Staff M at that time. During an interview with The Unit Manager on 09/24/25 at 11:50 AM, she was brought to Resident #10's room and made aware that the resident was observed twice that morning with the head of her bed flat with the enteral feed infusing.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record reviews, observations, and interviews the facility failed to provide care and services for nebulizer and tracheal suctional for 3 of 3 sampled residents, as evidenced by failure to follow procedure for tracheal (opening that connect voice box to passage to airway) suctioning (remove secretions to keep airway open) and physician order for administration of oxygen for Resident #10, failure to follow physician orders for administration of nebulizer treatment and storage of nebulizer equipment for Resident #94, and failure to store nebulizer equipment properly for Resident #39. The findings included: Review of the facility policy titled Tracheal Suctioning revised 08/24/17, documented in part Tracheal suctioning is an effective way to maintain a clear airway and to aide in the removal of secretions for residents who are unable to clear their secretions with coughing. Procedure: Hyperventilate the resident either manually or mechanically for a few breaths. Assess resident condition and response. Document. Review of the policy titled Nebulizer (small volume nebulizer) revised 03/20/2018, documented in part. Procedure: Evaluate the resident. Establish respiratory rate pulse, oxygen saturation and breathe sounds. Disassemble the device and rinse the mouthpiece and nebulizer with water and air dry. Place entire unit in a bag to be maintained in the resident's room. 1) Record review revealed Resident #10 was admitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 99 on a 0-15 scale indicating severe cognitive impairment. Review of the care plan dated 08/16/25 revealed a documented focus that Resident #10 had a tracheostomy related to impaired breathing mechanics and staff will ensure oxygen settings via tracheostomy and suction as necessary. Another focus revealed that the resident needed oxygen therapy related to ineffective gas exchange with a goal the resident will have no signs of poor oxygen absorption. An observation conducted on 09/24/25 at 10:56 AM, Resident #10 noted with oxygen via tracheostomy, with concentrator set at 4 liters per minute. Photographic evidence obtained. Review of a physician order dated 04/29/25, instructed staff to administer oxygen to Resident #10 continuously at 2 liter per minute via tracheostomy. During an interview on 09/24/2025 at 5:36PM, when asked how much oxygen Resident #10 was supposed to be on, Staff K, Licensed Practical Nurse (LPN) stated, I think 2L. An observation was conducted on 09/24/2025 at 5:10 PM with Staff K, LPN performing tracheal suctioning. She gathered the supplies and set them up on Resident #10 bedside table. Staff K, LPN, removed the oxygen from the tracheostomy and began to suction resident. She suctioned the resident twice and as she continued to suction the resident, she stated, I forgot my pulse ox, so I can check the resident's oxygen level. Also, I forgot to hyper oxygenate (administer oxygen prior) the resident before I started. Staff K, LPN continued with suctioning the resident. Review of the vital signs on 09/24/25 did not reveal documentation of an oxygen saturation assessed on Resident #10, after tracheal suctioning was performed by Staff K, LPN. Review the progress notes for 09/24/25 did not reveal documentation of an oxygen saturation assessed on Resident #10 or resident status after tracheal suctioning was performed by Staff K, LPN. 2) Record review revealed that Resident #94 was admitted to the facility on [DATE]. Review of quarterly assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 14 on a 0-15 scale, indicating no cognitive impairment. During an observation on 09/22/2025 at 2:24 PM in Resident #94's room a nebulizer mask was noted hanging on bed frame touching the floor. The nebulizer was dated 9/11/25. Photographic evidence obtained. Review of a physician order dated 01/20/25 instructed staff to administer Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) (steroid medication for breathing) 3 milliliters via inhalation four times a day for shortness of breath (SOB). A second order instructed staff to administer Acetylcysteine Inhalation Solution 20 % (Acetylcysteine) (used to treat cough and mucous) 2 milliliters via inhalation four times a day for SOB. Review of the care plan dated 08/28/25 revealed a focus documented that the resident had altered respiratory (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status and difficulty breathing due to history of respiratory failure, tracheostomy, and ventilator use with a goal that the resident will maintain normal breathing pattern as evidenced by regular respiratory rate, pattern with staff to administer medication and inhalers as ordered and monitor effectiveness and side effects. An observation was conducted on 09/23/2025 at 09:51 AM, a nebulizer mask dated 09/11/25 was observed on Resident #94's nightstand. During an interview on 09/25/2025 at 9:05 AM, when asked if Resident #94 had received the breathing treatments the spouse shook her head to acknowledge that she wasn't sure. She asked the resident in his language and showed him the nebulizer mask, and he stated, For 1 week and only 1 time. When asked if he had received the breathing treatment this week he stated No and shook his head no. Review of August and September Medication Administration Record for Resident #94 revealed documentation of staff indicating that the nebulizer treatments were administered. 3) Record review reveal Resident #39 was admitted to the facility on [DATE]. Review of the quarterly assessment documented a Brief Interview Mental Status (BIMS) score of 15 on a 0-15 scale, indicating no cognitive impairment. During an observation on 09/22/25 at 10:50 AM, a nebulizer mask was noted hanging on Resident #39's bed post. The nebulizer mask was not stored in a bag. Photographic evidence obtained. During an observation on 09/23/2025 at 8:49 AM, a nebulizer mask was noted hanging on Resident #39's bed post. The nebulizer mask was not stored in a bag. Photographic evidence obtained. Review of a physician order dated 09/11/25 instructed staff to administer Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol give 3 milliliters via inhalation every three times a day for 5 days for cough. A second order dated 09/11/25 instructed staff to administer Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol give 3 milliliters via inhalation every 6 hours as need for SOB or congestion. Review of the September MAR revealed that staff had administered the nebulizer treatment. During an observation on 09/25/2025 at 9:23 AM, a nebulizer mask was noted hanging on Resident #39's bed post. The nebulizer mask was not stored in a bag. Photographic evidence obtained.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on facility assessment, staffing record review, and interview, the facility failed to ensure sufficient staff on 6 of 13 weekends reviewed as evidenced by failure to staff as per their facility assessment, failure to ensure provision of wound care on weekends and during the survey for 3 of 4 sampled residents (Residents #9, #10, and #76), and as evidenced by 11 grievances related to patient care logged from April 2025 to the survey date. The findings included: Review of the federal staffing numbers submitted for the third fiscal quarter of 2025 (04/01/25 through 06/30/25) revealed low weekend staffing. Review of the Facility Assessment, revised 02/19/25, documented a general staffing plan to meet resident needs as follows: a) The ratio of licensed nurses to residents on day shift would be 1:22 (7 AM to 3 PM). b) The ratio of licensed nurses to residents on the evening shift would be 1:29 (3 PM to 11 PM). c) The ratio of licensed nurses to residents on night shift would be 1:29 (11 PM to 7 AM). Note the nurses at this facility work 12 hours shifts, from 7 AM to 7 PM and 7 PM to 7 AM. d) The ratio of Certified Nursing Assistants (CNAs) to residents on day shift would be 1:9 (7 AM to 3 PM). e) The ratio of CNAs to residents on evening shift would be 1:9 (3 PM to 11 PM). f) The ratio of CNAs to residents on night shift would be 1:10 (11 PM to 7 AM). Review of the actual staffing, for weekends, revealed the following data for nursing that the facility did not follow their own facility assessment: g) On 04/19/25 the nurse to resident ratio was 1:33.33 on the day shift. h) On 04/26/25 the nurse to resident ratio was 1:25.25 on the day shift. i) On 06/22/25 the nurse to resident ratio was 1:25.75 on the day shift. Review of the actual staffing, for weekends, revealed the following dates for CNAs that the facility did not follow their own facility assessment: j) On 04/12/25 the CNA to resident ratio was 1:12.50 on the day shift. k) On 04/19/25 the CNA to resident ratio was 1:16.66 on the night shift. l) On 04/20/25 the CNA to resident ratio was 1:12.50 on the day shift. m) On 05/25/25 the CNA to resident ratio was 1:14.85 on the evening shift. n) On 06/06/25 the CNA to resident ratio was 1:15.57 on the night shift. o) On 06/07/25 the CNA to resident ratio was 1:11.44 on the day shift. During the initial pool process, three sampled residents, Resident #9, #10, and #76 stated their wound care was not being provided on weekends. An observation on Monday 09/22/25 in the morning revealed a dressing to the left leg of Resident #76 that was dated Friday 09/19/25. Record review revealed the dressing was ordered to be changed daily. Refer to F684 for details. Review of the grievance log from April 2025 through the survey date of 09/25/25 revealed the following grievances related to care and services: p) On 04/21/25 a grievance was lodged related to staff issues. The Regional Social Services Director was unable to locate the grievance report. q) On 04/29/25 a grievance was lodged related to staff inability to transfer a resident back into bed timely. r) On 05/19/25 a grievance was lodge related to a resident having to wait to be changed as the mechanical lift needed to be charged. s) On 05/20/25 a grievance was lodged related to a resident having to wait to be changed last. t) On 06/03/25 and 06/04/25 complaints were lodged related to improper incontinent care. u) On 08/18/25 a grievance was lodged related to care and services for a tracheostomy. v) On 08/26/25 a grievance was lodged related to personal care by a CNA. w) On 08/27/25 a grievance was lodged related to personal care by a CNA and lack of wound care by the nurses. x) On 09/02/25 and 09/03/25 complaints were lodged related to CNA care and services.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure standards of practice for administration of medication for 2 of 27 samples residents, as evidenced by failure to ensure medications not left at the bedside for Resident #39 and Resident #14. The findings included: 1) Record review reveal Resident #39 was admitted to the facility on [DATE]. Review of the quarterly assessment documented a Brief Interview Mental Status (BIMS) score of 15 on a 0-15 scaled, indicating no cognitive impairment. During an observation on 09/22/25 at 10:50 AM, Resident #39 was noted sleeping in his bed. A clear medication cup with 2 white capsules was observed on his bedside table. During an interview 09/22/2025 3:22 PM, when asked did you take the pills that were left in a medicine cup on your bedside table, Resident #39 he stated. Yes. When asked do you know what the medications was for, he stated, I pretty much know the medications I take when I see them and if it's something I don't recognize, I will let them know, because they make mistakes. The pills were white and they were for the pain in my legs. During an interview on 09/22/2025 at 3:30 PM, when asked did you leave medication at the bedside for Resident #39, Staff O, Licensed Practical Nurse (LPN) asked, There was medications at the bedside? Staff O was made aware that there were 2 white capsules in a medication cup observed on the resident's bedside table this morning. She stated, They wasn't from me, I watched him take his pills. When asked to see the resident's medications, Staff O, LPN, showed a packet of white capsules with a label that read Gabapentin 100mg capsules. She said he takes 3 pills in the morning. When asked what time you gave him his morning medications, Staff O, LPN stated It was at 9:36 AM. Care plan dated 08/29/25 revealed a documented focus that Resident #94 has both cognition and communication deficit which include impaired thought processes, difficulty making decisions, short term memory loss with a goal that the resident will remain oriented to person, place, situation and time. Review of a physician order dated 05/19/25 instructed staff to administer Gabapentin Oral Tablet 100 MG (Gabapentin), give 3 tablets by mouth two times a day for neuropathy (nerve pain). 2) Record review revealed Resident #14 was admitted to the facility on [DATE]. Review of the comprehensive assessment date 04/23/25 documented a Brief Interview Mental Status (BIMS) score of 05 on a 0-15 scale, indicating severe cognitive impairment. Review of medical history revealed a diagnosis of Alzheimer's (memory loss). An observation of medication administration was conducted with Staff K, Licensed Practical Nurse (LPN) on 09/24/2025 at 08:40AM. She was observed administering the medications poured for Resident #14. After she administered the medications, surveyor noted a small white round pill on the resident's nightstand that was not in a cup. Staff K, LPN was called over to look at the pill sitting on the nightstand and verified that it was a pill. The pill was removed from the room in a napkin and taken to the med cart and placed on a pink tray. The ADON (assistant director of nursing) walked over to the medication cart and asked what was wrong. She was made aware that a pill was found on Resident #14's nightstand. The ADON looked at the pill and picked it up and placed the pill in a clear medication cup, she asked what the pill was. At that time the medication was not identified. After reviewing orders and medication prescribed to Resident #14, with Staff K, LPN, the medication was still not identified. The medication was disposed of properly.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to monitor behaviors and side effects of medications used for mood disorder, for 1 of 5 sampled residents, Resident #9. The findings included: Review of the record revealed Resident #9 was readmitted to the facility on [DATE] with a diagnosis to include Post Traumatic Stress Disorder (PTSD). Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 12, on a 0 to 15 scale, indicating the resident had moderate cognitive impairment. Review of the current orders revealed Resident #9 had been receiving Valproic Acid 500 milligrams (mg) three times daily since 06/25/25 for a mood disorder. Review of the September 2025 Medication Administration Record (MAR), the Treatment Administration Record (TAR), and corresponding nursing progress notes lacked any documented side effect or behavior monitoring for the Valproic Acid. During an interview on 09/22/23 during the initial pool screening, when asked about his PTSD, Resident #9 became very emotional, and explained he served in the Army, was in combat and wounded four times, including a hit and run accident in South Florida, which left him unable to walk. He also spoke of his family and continued with tears noted. When asked what triggers him, Resident #9 stated it was mainly just when his history was brought up in conversation. On 09/24/25 at 12:04 PM Staff K, Licensed Practical Nurse (LPN), was interviewed and asked what was done if a resident presented with behavior issues. Staff K, LPN, stated that it was documented in the nurse's progress notes and a psychological evaluation would be requested. When asked if Resident #9 had acted out or had any behavior, Staff K, LPN, stated he had not done so with her, but she had heard otherwise from other staff. During an interview on 09/24/25 at 12:06 PM, when asked if Resident #9 acted out or exhibited any behaviors, Staff Q, Certified Nursing Assistant (CNA), stated Resident #9 had declined bathing and had acted out by yelling and screaming at her to get out of the room. Staff Q stated that when this had occurred, she had alerted the nurse on duty regarding his behavior. During a side-by-side review of the record and interview on 09/25/25 at 2:54 PM, the Assistant Director of Nursing (ADON) was informed of the lack of side effect and behavior monitoring for Resident #9. The ADON agreed with the findings.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record reviews and interviews, the facility failed to ensure that it was free of medication errors for 2 of 4 sampled residents, as evidenced by a medication error rate of 17.14% (6 errors) with 35 opportunities due to failure to ensure that Resident #85 and Resident #42 received medications as ordered and were available. The findings included: 1) During an observation of medication administration on 09/24/25 at 8:53 AM, Staff K, LPN prepared a total of 7 pills for Resident #85. She stated, I do not have the inhalers to administer, because they have not arrived from the pharmacy. I will have to call pharmacy to follow up. When asked which inhalers you don't have, Staff K stated The Mometasone and Budesonide. The resident just told me that he hasn't had them for a few days. Staff K, LPN entered the resident's room to administer the medications she had prepared. The resident asked if his gout medication was in the medicine cup, she stated, Yes, the allopurinol is in there. Staff K, LPN told the resident that she will follow up on getting the inhalers reordered. After administration of the medications Staff K, LPN was asked to look in computer to see if it showed when the inhalers were reordered, she said the Mometasone furoate (steroid inhaler) was reordered on 09/18/25 and Budesonide (steroid medication for breathing) was reordered on 09/19/25. Review of the physician orders and reconciliation of the medications administered revealed that Resident #85 had the following physician orders which were not administered during medication observation: Docusate Sodium Capsule give 1 capsule by mouth two times a day for constipation Hold for loose stools. Vitamin D (Ergocalciferol) capsule give 1 capsule by mouth one time a day every Wednesday for supplement. Fluticasone-Salmeterol Inhalation Aerosol 45-21MCG/ACT 1 application inhale orally twice a day for shortness of breath (SOB). Mometasone Furoate Inhalation Aerosol 100 MCG/ACT 2 puffs inhale orally twice a day for SOB/Wheezing. Budesonide Inhalation Suspension 0.5 MG/2ML 1 application inhale orally three times a day for SOB. During an interview on 09/25/2025 at 9:10 AM, when asked did you receive your inhalers last night, Resident #85 stated, No I didn't. When asked do you receive nebulizer treatments, he stated Yes, sometimes at night. When asked again if he only received the nebulizer treatments at night, the resident stated, Yes. During an interview on 09/25/2025 at 9:20 AM, when asked how many inhalers were not administered to Resident #85 during observation of medication pass, Staff K, LPN stated, Two. When asked do you recall what they were, she stated, I will look, she said it was Mometasone and Budesonide. When asked if there were any other inhalers that the resident was supposed to receive in the morning, she stated, I don't think so. I know that he has 2 of them. Staff K, LPN was asked to look at Resident #85s orders and the medication administration record (MAR) she signed on 09/24/25 during morning med pass, Staff K, LPN reviewed the orders and realized that the resident had an order for Fluticasone-Salmeterol and stated, I didn't realize he had an order for this inhaler. When asked was the resident supposed to get a nebulizer treatment, she stated, You mean with the machine? Oh yes, I remember he does get that, and I'm supposed to stay with him for 15mins while he gets it. She was made aware that the Budesonide was the medication that is used for the nebulizer treatment and administration of a nebulizer was not observed. Staff K stated, I'm sorry. I got confused. When asked did you administer a nebulizer treatment, she stated No. When asked did you administer the Colace on 09/24/25 that was scheduled at 9:00 AM during med observation, she stated, No, he gets it twice a day and I gave him the evening dose. When asked did you administer the Vitamin D on 09/24/25, that was scheduled at 9:00 AM during med observation, she stated No, I gave it to him later in the afternoon. Review of the time stamped medication administration audit report for 09/24/25 for Resident #85 revealed documentation of Colace administered at 9:06 AM on 09/24/25, Vitamin D was documented as given at 9:06AM on 09/24/25, Budesonide was documented as given at 3:52 PM on 09/24/25, Fluticasone-Salmeterol was documented as given at 11:32 AM on 09/24/25 and Mometasone Furoate was documented as given at 3:54 PM on 09/24/25. During an interview on 09/25/25 at 10:15AM, the Pharmacy Consultant stated, I just want to let you know that I am going to make sure Resident #85 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105558	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER Aviata at West Palm Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 5065 Wallis Road West Palm Beach, FL 33415	
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	has his inhalers today. The resident did not have one of the inhalers, because his insurance no longer covers it, we got the doctor to change that inhaler to a different one. When asked why the nurses are signing that the inhalers are being administered if they don't have them, the resident says he has not had them in a few days, I really don't know, but the Regional Nurse is going to do some education with the staff. 2) On 09/24/25 at 8:40 AM during medication administration observation for Resident #42, Staff N, Licensed Practical Nurse (LPN), verified with this surveyor a total of 6 pills were then given to Resident #42. Upon review of the electronic medical record, the nurse documented that the resident received 7 pills. A review of the timestamped documentation for the medications revealed that both Vitamin B1 and Vitamin B Complex were administered on 09/24/25 at 8:45 AM. On 09/25/25 at 9:25 AM, Staff Nurse N was asked to see the pill bottle for Vitamin B Complex, the nurse was unable to locate the bottle in the cart.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record reviews, the facility failed to provide foods prepared in a sanitary manner and in accordance with professional standards for food safety. The findings included: 1. During the initial kitchen tour, on 09/22/25 at 9:01 AM, accompanied by the Dietary Manager, the following were noted: a. The concentration of the quaternary ammonia used for sanitizer in a red bucket in the processing area was less than 200 parts per million necessary to sanitize food equipment and surfaces. b. The paint was peeling from the wall at the left of the door in the dry storage area. c. The ceiling over the reach in freezer #2 was damaged in a manner indicative of being wet. d. There was an accumulation of dust and condensation on the vents of the air conditioning unit in the dry storage area. e. Cleaned and sanitized pitchers used to provide fluids to the residents during meals had residue left from the date stickers that were placed on them. f. The hand washing sink was not sealed to the wall as the caulk had appeared to have worn. g. There was an accumulation of residue on the blade of the counter mounted can opener. h. The Teflon coating on a skillet was worn and appeared to be coming off of the cooking surface of the skillet. i. Plates that were not in use on a shelf in the hot holding area were not stored inverted in a manner to prevent dust and debris from contaminating the plates. j. There was peeling paint and an accumulation of rust on the ceiling over the coffee maker. k. Staff C, Dietary Aide, was observed removing a pair of single use gloves. Prior to donning another pair of clean single use gloves, the Dietary Aide did not perform hand hygiene. When asked about performing hand hygiene, the Dietary Aide stated that she was not aware of the need to do so when changing gloves. At the conclusion of the initial kitchen tour, the Dietary Manager acknowledged understanding of the concerns. 2. During a tour of the Food Service Area, where meals are placed into a cart to be transported to the units and the Dining Room, on 09/22/25 at 9:45 AM, the following were noted: a. On the shelves by the entrance from the service corridor, there were 16 cases of expired nutrition supplements - each case contained 24 8 ounce cartons of supplement* 1 case was stamped with an expiration date of 11/01/24.* 1 case was stamped with an expiration date of 01/01/25.* 4 cases were stamped with an expiration date of 03/01/25.* 2 cases were stamped with an expiration date of 07/01/25.* 1 case was stamped with an expiration date of 08/01/25.* 6 cases were stamped with an expiration date of 09/01/25. b. Accumulation of debris under and behind pellet warmer and under and behind the reach in cooler. c. There was a hole in the wall to the right of the hand washing sink. At the conclusion of the tour, the Dietary Manager acknowledged the findings. 3. During the follow up kitchen tour, on 09/24/25 at 11:13 AM, there was an accumulation of mold around the inside of the door to the ice machine in the food service area.		