STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105795	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Coral Bay	2939 S Haverhill Rd 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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide follow-up care for a surgical wound in a timely manner as evidenced by not attending to follow up surgical appointment and not informing the surgeon of the worsening condition of the resident's wound for 1 of 3 sampled residents (Resident #1).The findings included:Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses included Diabetes, Chronic Kidney Disease, and Right Below the Knee Amputation, status post left foot toes amputation. A comprehensive assessment dated [DATE] documented the resident was cognitively intact and required partial/moderate assistance with activities of daily living. A review of Resident #1's care plan revealed the resident did not have a care plan for the left foot surgical wound. A review of Resident #1's orders revealed an order dated 03/10/25 for intravenous (IV) antibiotics for 25 days (until 04/05/25) , and an order dated 03/12/25 to follow up with the surgeon and infectious disease.A review of Resident #1's records did not reveal any documentation of the resident's left foot surgical wound's condition, or any treatment provided from admission on [DATE] until 03/17/25. Further review of Resident #1's orders revealed an order dated 03/17/25 for wound care to cleanse the foot surgical wound with Normal Saline and apply a dry dressing one time only. An order dated 03/19/25 documented for a dressing change to left foot to cleanse with Normal Saline, and apply a wound vacuum-assisted closure (vac) three times a week on Monday, Wednesday, and Fridays. A review of Resident #1's Treatment Administration Record (TAR) revealed that the dressing change and wound vac were applied on 03/21/25. However, there is no documentation indicating that the treatment was performed on 03/24/25 and 03/26/25. Additionally, no explanation was provided for the missed treatments on those dates.Record review revealed an order dated 03/20/25 for an appointment with the surgeon on 03/27/25 at 3:15 PM. An order dated 03/25/25 documented an appointment with infectious disease on 04/01/25 at 2:30 PM. A review of Resident #1's progress notes revealed a note dated 03/27/25 at 8:02 PM that documented Resident #1 went to a doctor visit for his wound today. No new orders received. Resident has a follow up appointment on 04/10/2025 at 2:30 PM. Plan of care ongoing.A review of a progress note dated 04/01/25 at 9:53 PM documented Resident #1 returned from a doctor's appointment. Orders received to continue IV antibiotics until 04/05/25, then remove IV line. A follow up with podiatrist (surgeon) will be necessary.Further record review did not reveal any documentation of the resident's left foot surgical wound's condition, or any treatment provided until 04/26/25. A progress note dated 04/26/25 at 3:32 PM documented Resident #1's left foot wound culture was positive for Pseudomonas, antibiotics were changed and the resident was to continue to follow up with the surgeon. Record review did not provide any evidence that Resident #1 went to his scheduled surgeon appointment on 04/10/25. Furthermore there was no evidence Resident #1's surgeon was notified of a change in the condition of the resident's wound.A review of Resident #1's progress notes dated 04/30/25 revealed the resident had an appointment with infectious disease, and an IV antibiotic was initiated. Again, there was no evidence that Resident #1's surgeon was notified of a change in the resident's wound.A review of a physician progress note dated 05/02/25 at 2:28 PM documented: Wound is reviewed with wound care nurse, wound vac was on place, after removed showed infected tissue, fetid (bad smelling), with bone exposure and discoloration and soft area of bone consistent with osteomyelitis, purulent discharge, foul smell, Meropenen (antibiotic) on IV BID (twice daily) X 10 days, follow up with ID (infectious disease) and foot surgeon will be arranged by nursing.Further record review revealed Resident #1 was transferred to the hospital on [DATE] for evaluation of the left foot wound. Resident #1 returned to the facility on [DATE]. There was no documentation of Resident #1's surgeon being notified of the change in the resident's wound.Record review revealed an order dated 05/05/25 for an appointment with resident #1's surgeon on 05/07/25 at 2:15 PM.A review of Resident #1's progress notes dated 05/07/25 at 3:55 PM documented Resident #1 returned back from the doctor's office with an order to send the resident to the hospital for evaluation.An interview was conducted with the Director of Nursing (DON) on 07/02/25 at 3:00 PM. The DON acknowledged the above.