STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105320	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dade City Health and Rehabilitation Center	37135 Coleman Ave Dade City, FL 33525

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to honor a resident's decision to formulate an advance directive and did not ensure a residents' end-of-life wishes for Do Not Resuscitate (DNR) was honored for one (#3) of three residents sampled.On [DATE], when staff failed to verify Resident #3's resuscitation code status and performed Cardiopulmonary Resuscitation (CPR) against the documented resident's wishes. Resident #3 had a fully executed Do Not Resuscitate (DNR) order in the medical record dated [DATE]. The facility's failure to honor Resident #'s DNR status deprived her of a dignified death and likely resulted in severe pain and organ damage. Additionally, Resident #3 could not express her reaction to this event. Applying the reasonable person concept, Resident #3 would likely experience serious psychosocial harm by being resuscitated against her wishes. This failure resulted in the determination of Immediate Jeopardy occurring on [DATE]. During the survey, the survey team verified the implementation of the facility's immediate actions to remove the Immediate Jeopardy, and the Immediate Jeopardy was removed as of [DATE]. The scope and severity of F578 was reduced from J to a D which is no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings included:During an interview on [DATE] at 1:25 p.m., Staff B, Registered Nurse (RN), said on [DATE] at approximately 6:30 p.m. Resident #3 was observed non-responsive and without a palpable pulse. Staff B, RN stated she instructed the Certified Nursing Assistant (CNA) present to call a code. Staff B, RN said the staff response time was slower than expected and she initiated chest compressions. She stated after performing two chest compressions, she was informed the resident had a DNR order in place and she discontinued chest compressions.A review of Resident #3's admission record showed an initial admission date of [DATE], with diagnoses including dementia, Type 2 Diabetes Mellitus, vascular implants, osteoarthritis, Stage 2 chronic kidney disease, anxiety, depression, insomnia, hypertension and Hodgkin's Lymphoma.A review of Resident #3's order summary report as of [DATE], showed a Do Not Resuscitate (DNR) order, dated [DATE].A Review of Resident #3's medical record revealed the presence of a valid State of Florida Do Not Resuscitate Order (DNRO) (Form DH 1896), dated [DATE]. The DNRO was present and available to guide staff in honoring the resident's end-of-life wishes when discovered on [DATE] not breathing and without a pulse.A review of Resident #3's annual Minimum Data Set (MDS) assessment, dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 1 out of 15, indicating severe cognitive impairment.A review of Resident #3's care plan showed a focus area as follows: [Resident #3] has an established DNR (DO NOT RESUSCITATE) order in place, initiated on [DATE], created by the Social Worker.The interventions for this care plan focus included, Activate resident's advanced directives as indicated.On [DATE] at 11:33 p.m. a progress note authored by Staff A, Licensed Practical Nurse (LPN) showed the following: Staff approached me around 1830 [6:30 p.m.] and informed me that resident was not breathing fellow nurse and I pronounced time of death at 1838 [6:38 p.m.] as resident was apneic (not breathing) and without heartbeat. Informed Advanced Practice Registered Nurse, (APRN) and Director of Nursing, (DON) of resident's death. Contacted resident's [family member] .During an interview on [DATE] at 3:08 p.m. Staff H, CNA said on [DATE] she found Resident# 3's DNRO form in the Code Status Binders. Upon entering Resident #3's room, Staff B, RN was crawling off [Resident #3's] bed. Staff H, CNA stated [Staff B, RN] did not check if the resident had DNR orders.During an interview on [DATE] at 11:48 a.m. Staff E, LPN said on [DATE] she was standing by the medication cart when two or three CNAs came running around the corner and said Resident #3 was not breathing. She said the CNAs asked about the resident's code status. Staff E, LPN said she did not hear a code announced over the facility's overhead paging system. She stated she checked Resident #3's orders and found a Do Not Resuscitate (DNR) order in the electronic health record (EHR). She stated she immediately called staff. Staff E, LPN stated that upon entering Resident #3's room staff were looking in the CPR binder for the DNRO form.During an interview on [DATE] at 1:25 p.m., Staff B, Registered Nurse (RN), said her employment at the facility began mid-September of 2025. During orientation education and training was provided primarily through computer modules. Staff B, RN said during orientation, the facility did not provide education or training related to Code Blue procedures or DNR procedures. She was not trained how to locate a resident's code status in the computer. She did not know about the code blue binder until after Resident #3 was found not breathing and without a pulse on [DATE].During an interview on [DATE] at 3:27 p.m. with the Nursing Home Administrator (NHA), Director of Nursing (DON), and the Regional Nurse

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to protect the resident's right to be free from neglect for one resident (#3) out of three residents sampled.On [DATE], when staff failed to verify Resident #3's resuscitation code status and performed Cardiopulmonary Resuscitation (CPR) against the documented resident's wishes. Resident #3 had a fully executed Do Not Resuscitate (DNR) order in the medical record dated [DATE]. The facility's failure to honor Resident #3's DNR status deprived her of a dignified death and likely resulted in severe pain and organ damage. Additionally, Resident #3 could not express her reaction to this event. Applying the reasonable person concept, Resident #3 would likely experience serious psychosocial harm by being resuscitated against her wishes. This failure resulted in the determination of Immediate Jeopardy occurring on [DATE]. During the survey, the survey team verified the implementation of the facility's immediate actions to remove the Immediate Jeopardy, and the Immediate Jeopardy was removed as of [DATE]. The scope and severity of F600 was reduced from J to a D which is no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.Findings included:During an interview on [DATE] at 1:25 p.m., Staff B, Registered Nurse (RN), said on [DATE] at approximately 6:30 p.m. Resident #3 was observed non-responsive and without a palpable pulse. Staff B, RN stated she instructed the Certified Nursing Assistant (CNA) present to call a code. Staff B, RN said the staff response time was slower than expected and she initiated chest compressions. She stated after performing two chest compressions, she was informed the resident had a DNR order in place and she discontinued chest compressions.A review of Resident #3's admission record showed an initial admission date of [DATE], with diagnoses including dementia, Type 2 Diabetes Mellitus, vascular implants, osteoarthritis, Stage 2 chronic kidney disease, anxiety, depression, insomnia, hypertension and Hodgkin's Lymphoma.A review of Resident #3's order summary report as of [DATE], showed a Do Not Resuscitate (DNR) order, dated [DATE].A Review of Resident #3's medical record revealed the presence of a valid State of Florida Do Not Resuscitate Order (DNRO) (Form DH 1896), dated [DATE]. The DNRO was present and available to guide staff in honoring the resident's end-of-life wishes when discovered on [DATE] not breathing and without a pulse.A review of Resident #3's annual Minimum Data Set (MDS) assessment, dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 1 out of 15, indicating severe cognitive impairment.A review of Resident #3's care plan showed a focus area as follows: [Resident #3] has an established DNR (DO NOT RESUSCITATE) order in place, initiated on [DATE], created by the Social Worker.The interventions for this care plan focus included, Activate resident's advanced directives as indicated.On [DATE] at 11:33 p.m. a progress note authored by Staff A, Licensed Practical Nurse (LPN) showed the following: Staff approached me around 1830 [6:30 p.m.] and informed me that resident was not breathing fellow nurse and I pronounced time of death at 1838 [6:38 p.m.] as resident was apneic (not breathing) and without heartbeat. Informed Advanced Practice Registered Nurse, (APRN) and Director of Nursing, (DON) of resident's death. Contacted resident's [family member] .During an interview on [DATE] at 12:30 p.m. Staff F, CNA stated upon entering Resident #3's room she [Resident #3] was passed out. Staff F, CNA said, Staff B, RN was on top of [Resident #3] giving two chest pumps, she got off quick. Staff B, RN directed me to call 911 and I hurried up to call. Staff F stated later Staff A, LPN told her CNAs are not allowed to call 911.During an interview on [DATE] at 11:36 a.m. Staff D, CNA, assigned to care for Resident #3 on [DATE], stated upon picking up Resident #3's dinner tray Resident #3 was not responding. Staff D, CNA called Staff B, RN to the resident's room. Staff D, CNA stated Staff B, RN provided one or two chest compressions before stopping. Staff D stated Staff B, RN appeared to be having difficulty breathing and Staff B said she was having an asthma attack.During an interview on [DATE] at 11:48 a.m. Staff E, LPN said on [DATE] she was standing by the medication cart when two or three CNAs came running around the corner and said Resident #3 was not breathing. She said the CNAs asked about the resident's code status. Staff E, LPN said she did not hear a code announced over the facility's overhead paging system. She stated she checked Resident #3's orders and found a Do Not Resuscitate (DNR) order in the electronic health record (EHR). She stated she immediately called staff. Staff E, LPN stated that upon entering Resident #3's room staff were looking in the CPR binder for the DNRO form.During an interview on [DATE] at 1:25 p.m., Staff B, RN stated she began employment at the facility mid-[DATE]. She stated during orientation the facility provided general orientation through an online platform. Staff B, RN said the facility did not provide education or training related to CPR or DNR procedures.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, interviews and record review, the facility failed to ensure the residents' wishes were honored related to Do Not Resuscitate (DNR) orders for one (#3) of three residents sampled.On [DATE], when staff failed to verify Resident #3's resuscitation code status and performed Cardiopulmonary Resuscitation (CPR) against the documented resident's wishes. Resident #3 had a fully executed Do Not Resuscitate (DNR) order in the medical record dated [DATE]. This failure resulted in the determination of Immediate Jeopardy occurring on [DATE]. During the survey, the survey team verified the implementation of the facility's immediate actions to remove the Immediate Jeopardy, and the Immediate Jeopardy was removed as of [DATE]. The scope and severity of F678 was reduced from J to a D which is no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.Findings included:During an interview on [DATE] at 1:25 p.m., Staff B, Registered Nurse (RN), said on [DATE] at approximately 6:30 p.m. Resident #3 was observed non-responsive and without a palpable pulse. Staff B, RN stated she instructed the Certified Nursing Assistant (CNA) present to call a code. Staff B, RN said the staff response time was slower than expected and she initiated chest compressions. She stated after performing two chest compressions, she was informed the resident had a DNR order in place and she discontinued chest compressions.A review of Resident #3's admission record showed an initial admission date of [DATE], with diagnoses including dementia, Type 2 Diabetes Mellitus, vascular implants, osteoarthritis, Stage 2 chronic kidney disease, anxiety, depression, insomnia, hypertension and Hodgkin's Lymphoma.A review of Resident #3's order summary report as of [DATE], showed a Do Not Resuscitate (DNR) order, dated [DATE].A Review of Resident #3's medical record revealed the presence of a valid State of Florida Do Not Resuscitate Order (DNRO) (Form DH 1896), dated [DATE]. The DNRO was present and available to guide staff in honoring the resident's end-of-life wishes when discovered on [DATE] not breathing and without a pulse.A review of Resident #3's annual Minimum Data Set (MDS) assessment, dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 1 out of 15, indicating severe cognitive impairment.A review of Resident #3's care plan showed a focus area as follows: [Resident #3] has an established DNR (DO NOT RESUSCITATE) order in place, initiated on [DATE], created by the Social Worker.The interventions for this care plan focus included, Activate resident's advanced directives as indicated.A review of Resident #3's care plan meeting minutes, dated [DATE] showed: Advance Directive: DNR.On [DATE] at 11:33 p.m. a progress note authored by Staff A, Licensed Practical Nurse (LPN) showed the following: Staff approached me around 1830 [6:30 p. m.] and informed me that resident was not breathing fellow nurse and I pronounced time of death at 1838 [6:38 p.m.] as resident was apneic (not breathing) and without heartbeat. Informed Advanced Practice Registered Nurse, (APRN) and Director of Nursing, (DON) of resident's death. Contacted resident's [family member] .During an interview on [DATE] at 11:36 a.m. Staff D, CNA, assigned to care for Resident #3 on [DATE], stated upon picking up Resident #3's dinner tray Resident #3 was not responding. Staff D, CNA called Staff B, RN to the resident's room. Staff D, CNA stated Staff B, RN provided one or two chest compressions before stopping. Staff D stated Staff B, RN appeared to be having difficulty breathing and Staff B said she was having an asthma attack.During an interview on [DATE] at 11:48 a.m. Staff E, LPN said on [DATE] she was standing by the medication cart when two or three CNAs came running around the corner and said Resident #3 was not breathing. She said the CNAs asked about the resident's code status. Staff E, LPN said she did not hear a code announced over the facility's overhead paging system. She stated she checked Resident #3's orders and found a Do Not Resuscitate (DNR) order in the electronic health record (EHR). She stated she immediately called staff. Staff E, LPN stated that upon entering Resident #3's room staff were looking in the CPR binder for the DNRO form.During an interview on [DATE] at 12:30 p.m. Staff F, CNA said when she entered Resident #3's room the she [Resident #3] was passed out. Staff F, CNA said, she saw Staff B, RN on top of [Resident #3] giving two chest pumps, she got off quick. Staff B, RN directed me to call 911 and I hurried up to call. Later Staff A, LPN told me CNAs are not allowed to 911.During a telephone interview on [DATE] at 3:05 p.m. Staff G, CNA said on [DATE] when Staff E, LPN said Resident #3 was a DNR, I started hollering, she [Resident #3] is a DNR.During an interview on [DATE] at 3:27 p.m. with the Nursing Home Administrator (NHA), Director of Nursing (DON), and the Regional Nurse Coordinator (RNC) the DON said Staff B, RN did not check the resident's code status before initiating Cardiopulmonary Resuscitation (CPR). The DON said the facility's expectation is for two nurses to verify a resident's code

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to ensure nursing staff were competent in identifying and honoring cardiopulmonary resuscitation wishes for one (#3) of three residents sampled On [DATE], when staff failed to verify Resident #3's resuscitation code status and performed Cardiopulmonary Resuscitation (CPR) against the documented resident's wishes. Resident #3 had a fully executed Do Not Resuscitate (DNR) order in the medical record dated [DATE]. This failure resulted in the determination of Immediate Jeopardy occurring on [DATE]. During the survey, the survey team verified the implementation of the facility's immediate actions to remove the Immediate Jeopardy, and the Immediate Jeopardy was removed as of [DATE]. The scope and severity of F726 was reduced from J to a D which is no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.Findings included:During an interview on [DATE] at 1:25 p.m., Staff B, Registered Nurse (RN), said on [DATE] at approximately 6:30 p.m. Resident #3 was observed non-responsive and without a palpable pulse. Staff B, RN stated she instructed the Certified Nursing Assistant (CNA) present to call a code. Staff B, RN said the staff response time was slower than expected and she initiated chest compressions. She stated after performing two chest compressions, she was informed the resident had a DNR order in place and she discontinued chest compressions.A review of Resident #3's admission record showed an initial admission date of [DATE], with diagnoses including dementia, Type 2 Diabetes Mellitus, vascular implants, osteoarthritis, Stage 2 chronic kidney disease, anxiety, depression, insomnia, hypertension and Hodgkin's Lymphoma. A review of Resident #3's order summary report as of [DATE], showed a Do Not Resuscitate (DNR) order, dated [DATE].A Review of Resident #3's medical record revealed the presence of a valid State of Florida Do Not Resuscitate Order (DNRO) (Form DH 1896), dated [DATE]. The DNRO was present and available to guide staff in honoring the resident's end-of-life wishes when discovered on [DATE] not breathing and without a pulse. A review of Resident #3's annual Minimum Data Set (MDS) assessment, dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 1 out of 15, indicating severe cognitive impairment. A review of Resident #3's care plan showed a focus area as follows: [Resident #3] has an established DNR (DO NOT RESUSCITATE) order in place, initiated on [DATE], created by the Social Worker.The interventions for this care plan focus included, Activate resident's advanced directives as indicated.On [DATE] at 11:33 p.m. a progress note authored by Staff A, Licensed Practical Nurse (LPN) showed the following: Staff approached me around 1830 [6:30 p.m.] and informed me that resident was not breathing fellow nurse and I pronounced time of death at 1838 [6:38 p.m.] as resident was apneic (not breathing) and without heartbeat. Informed Advanced Practice Registered Nurse, (APRN) and Director of Nursing, (DON) of resident's death. Contacted resident's [family member] .During an interview on [DATE] at 1:25 p.m., Staff B, RN stated she began employment at the facility mid-[DATE]. She stated during orientation the facility provided general orientation through an online platform. Staff B, RN said the facility did not provide education or training related to CPR or DNR procedures, instruction on how to locate a resident's code status in the computer system, or the location and contents of the CPR binder. She stated after Resident #3 expired, she learned the DNRO forms were in the Code Status Binders.During an interview on [DATE] at 4:16 p.m. with the Nursing Home Administrator (NHA) the Regional Nurse Consultant (RNC), and the Regional Director of Operations (RDO). The NHA said Resident #3 was a DNR and she was told compressions were performed. The NHA read Staff A, LPN's witness statement. Staff A, LPN wrote [on [DATE]] Resident #3 was assessed with Staff E, LPN and they verified no heartbeat and death was pronounced at 6:38 p.m. messaged the ARNP . informing her of resident's passing around 1900 [7:00 p.m.]. The NHA said on [DATE] Resident #3's code status was not verified before chest compressions were performed. Staff did not follow the procedure to overhead page there was a code blue emergency. Licensed nurses are expected to notify EMS and a CNA notified EMS. The RNC said since incident all staff members have participated in code blue drill and licensed nurses have completed the code blue checklist. The RNC said the facility has provided additional education to CNAs regarding their role during a code blue emergency.During an interview on [DATE] at 1:46 p.m. Staff C, Licensed Practical Nurse, (LPN) Unit Manger UM) said new employee orientation consist of education/training using a collaboration platform and licensed nurses receive a minimum of three days orientation in the nursing unit. Staff C, LPN, UM said code blue checklist and mock Code Blue drills were implemented after the [DATE] event During an interview on [DATE] at 4:00 p.m. the RNC said the Code Blue