STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinellas Park FL Opco, LLC	8701 49th St N Pinellas Park, FL 33782

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to protect the residents' right to be free from neglect by failing to honor a resident's expressed Advanced Directive for end of life by failing to ensure life saving measures of cardiopulmonary resuscitation (CPR) were performed, for one resident (#3) of two residents sampled. The failure to initiate CPR for approximately 35 minutes resulted in physical pain and ultimate death for Resident #3.On [DATE] Resident #3 was found unresponsive and absent of vital signs by facility staff and CPR was not performed. On [DATE] Resident #3 had a meeting with the facility's Advanced Practical Registered Nurse (APRN) and expressed his Advance Care wishes. The progress note read, We had an extensive conversation concerning full code vs. (versus) DNR (Do Not Resuscitate) status. Patient verbalizes an understanding of the difference and elects/confirms full code status. On [DATE] at 5:30 a.m. Resident #3 was found unresponsive by Staff A, CNA (Certified Nursing Assistant). Staff A notified his nurse, Staff B, LPN (Licensed Practical Nurse). Facility staff denied Resident #3 his right to be resuscitated as CPR was not initiated by facility staff. On [DATE] at 6:09 a.m. EMS (Emergency Medical Services) arrived to the facility, and the paramedics confirmed Resident #3's code status and initiated CPR. EMS performed CPR on Resident #3 for approximately 45 minutes. Resident #3 was pronounced dead at the facility.This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to Resident #3 and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to a D after verification of removal of immediacy of harm.Cross reference to F678 and F726.Findings included: On [DATE] at 11:14 a.m. a telephone interview was conducted with Staff A, CNA. Staff A stated Resident #3 was not assigned to her. She said she worked with Staff B, CNA, who had come to her hallway and stated her resident was not responding and he was not moving. She said this was around 5:30 a.m. Staff A said as she was walking down the hall she ran into Staff C, Licensed Practical Nurse (LPN) who was at the desk on the phone. She said she notified Staff C the resident was not responding and she said, Yes, I'm on my way, but she continued with what she was doing. Staff A said she went to the room and Staff B, CNA, was in the room. Staff A said Staff B was shaking Resident #3 and was calling his name. Staff A said, I checked his pulse on his arm and neck and he was not breathing. A few minutes later, the nurse, Staff C, came. She started calling him, I told her I did not get a pulse. She left to get a pulse oximeter. Staff A stated Resident #3 was laying on the bed, hanging on the side of the bed and one of the legs was off the bed. Staff A stated she and the other CNA, Staff B, positioned the resident back in bed. She said the nurse, Staff C came and put on the oximeter on the resident and his oxygen level was 60 (indicating moderate to severe hypoxemia, low blood oxygen). Staff A reported Staff C said, That is kind of low. Staff A said to the nurse, I said he is not here. Staff A stated she asked Staff C, Don't we need to call code?. Staff C said to hold on. She said let me go and check his status. Staff A stated Staff C left the room again and after a couple minutes she came and said [Resident #3] was a Full Code. Staff A stated, I said we need to start CPR. She said I should call another nurse. She said she did not know how to call the code. Staff A (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated they were all standing there, waiting for her [Staff C, LPN] to tell them what to do. Staff A stated B, CNA asked, Do you want me to get another nurse? She stated Staff C did not answer so, at this point she said let me go. Staff A stated they all left the room, and she and Staff B went to get the RN (Registered Nurse) from upstairs. She said she took the stairs and Staff B took the elevator. She stated after she came downstairs she went to get the crash cart. Staff A stated Resident #3 was by himself during this time. She stated it was hard to tell how long it took. She said the time was moving slowly and fast at the same time. Staff A stated when she got to the room, the nurses, Staff D, RN, Staff E, LPN and Staff C, LPN all came in together. Staff A stated they were all in the room and Staff C was telling them what was happening. She said and the one nurse, Staff D, RN came and she was checking his oxygen and asking what happened. Staff A confirmed no one was doing CPR. She stated at this time the nurses took over. She said, I did not see anyone doing CPR. The nurses were asking us questions, they were from another floor. Staff A stated Staff D, RN said we needed to call 911. Staff A stated she asked Staff C if she had called, she said she was on her way down to call. Staff A stated she left the room together with Staff C and went to her assignment. She sated Staff B, CNA was very upset and she was trying to calm her down. She stated Staff B was saying maybe she could have done something different. Staff A stated she took Staff B to her assignment, and they started attending to her residents. Staff A stated the whole thing probably took about 15 minutes. She said they were in her hall when they heard the ambulance people coming up the stairs. She said they asked her where the room was. Staff A said, I believe it was around 5:45 a.m. now. She said she walked EMS (Emergency Medical Services) to Resident #3's room and left them in the room. Staff A said, When I walked in with EMS, I did not see anyone doing CPR. EMS asked what was going on. EMS asked for the paperwork for the resident, they asked, Why isn't anyone doing CPR if this man is a Full Code? Staff A stated she walked out of the room as EMS started CPR. She said later on, she gave a statement. Staff A said, I told them the truth. I said, code blue was not called and CPR was never initiated, not by our staff. Staff A, CNA stated having been suspended pending investigation.Review of the admission record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses to include Type 2 diabetes, other persistent atrial fibrillation, abnormal gait, need for assistance with personal care, blindness of Right eye, shortness of breath, muscle wasting, mood disorder and essential hypertension.Review of the physician order summary report for Resident #3 dated [DATE] revealed code status orders; Full Code, dated [DATE].Review of form 3008 (Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form) dated [DATE], revealed upon admission to the facility Resident #3 did not have a DNR (Do Not Resuscitate) order in place. The form revealed Resident #3 was alert, oriented, follows instructions and was capable to make healthcare decisions.Review of an Advanced Practical Registered Nurse (APRN) progress note revealed Advance Care Planning (ACP) occurred on [DATE]. The note read, Face to face conversation with patient for greater than 16 minutes to discuss ACP/GOC (goals of care) conversation. We had an extensive conversation concerning Full Code vs. (versus) DNR (Do Not Resuscitate) status. Patient verbalizes an understanding of the difference and elects/confirms Full Code status.Review of a physician progress note dated [DATE] revealed, Advanced Care Planning (ACP): Reviewed code status in the facility EMR (Electronic Medical Record) and discussed with patient. Verified ACP in the facility EMR. Code status - Full Code.Review of an admission/readmission nursing evaluation dated [DATE] revealed:15. code Status, Full Code - CPR. The neurological assessment revealed the resident was alert, oriented to person, place, time and situation. Resident #3 communicated appropriately with no obvious problems. Review of a care plan for Resident #3 initiated on [DATE] revealed a focus - Resident has an established advanced directive: Resident is Full Code. No other AD (Advanced Directive) on file. The goal indicated the resident or healthcare decision maker shall participate in decisions regarding medical care and treatment by next review date, initiated on [DATE]. Interventions included to allow opportunities for expression of feelings or concerns. Maintain signed consent and review annually. Promote (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	opportunities for resident healthcare decision maker to participate in decisions regarding care.Review of a 5-day Minimum Data Set (MDS) for Resident #3 dated [DATE] revealed in Section B, the resident's speech was clear, makes self-understood and understands others. Section C revealed the resident had a brief interview for mental status (BIMS) score of 14, indicating intact cognition. Section GG revealed the resident required partial/moderate assistance for ADLs (Activities of Daily Living). Review of Resident #3's physician note dated [DATE] revealed: Resident was seen today for follow up on stability. He was seen in the chair on the hallway. Chart, MAR (medication administration record) and recent vitals reviewed. No acute issues or significant changes since last evaluation. Resident appears at baseline and remains clinically stable. No new complaints voiced. Current diagnosis and plan of care reviewed; no changes indicated at this time. Continue current treatments. POC (plan of care) was reviewed and discussed with the resident, nursing staff, and PCP (primary care physician). Denies fever, chills, SOB (shortness of breath). Code Status: Full Code. Review of a physician progress note dated [DATE], showed Resident #3's code status was Full Code.A telephone interview was conducted on [DATE] at 11:02 a.m. with Staff B, CNA, assigned to Resident #3. The CNA said, I found him [Resident #3] sometime close to 6:00 a.m. He was my resident. I went to the room and found him unresponsive. She stated she spoke to the nurse Staff C, LPN, she was on the med cart. Then she called another CNA, Staff A. Staff B stated Staff A went to the room with her and also tried to wake Resident #3 up. Then Staff C, LPN came. She stated Staff C, LPN said, He is not breathing. She said she needed another nurse, she said she did not know how to call the code on the intercom. Staff B stated she ran upstairs and got another nurse. Staff B stated being new and had not done a code before. She said she went and got Staff E, LPN and Staff D, RN. She said they all went down to the room. Staff B stated she started to have a panic attack, so she left the room. She said she could not tell what was said or done. Staff B, CNA said, I did not observe anybody doing CPR. Staff B answered, No, I did not observe Staff B, LPN or the other nurses doing CPR. There was no paging, no one called code blue. I do not re-call any of that. Staff B stated Resident #3 was not fully dependent, he was an assist. She said If he had an accident she would change him. She stated he wore briefs at night and in morning he would be assisted to the bathroom. She stated they document after they provide care. She said there was no documentation because she did not toilet him at all that night. Staff B stated her shift started at 11:15 p.m. Staff B said, I checked on him earlier, around 4:00 a.m. and he was breathing, until sometime close to 6:00 a.m., not exactly 6:00 a.m. I found him unresponsive. Staff B stated time was moving fast and it was hard to tell what was happening.A telephone interview was conducted with Staff C, LPN on [DATE] at 11:36 a.m. Staff C was assigned to Resident #3 on [DATE]. She stated she only worked night shift and had taken care of the resident before. She said he was legally blind, he had cardiac issues, he always asked for snacks, was wearing oxygen, and he needed ADL (Activities of Daily Living) assistance. He could eat/drink by himself. His B/P (blood pressure) was okay as he was taking medications. Staff C, LPN said on that night it was around 1:20 a.m. or 2:00 a.m. when she changed a dressing on his roommate's leg. She said Resident #3 was sleeping, or I should say he appeared to be sleeping and in no distress. Staff C stated around 6:00 a.m. his CNA, Staff B came and said to take a look because he does not look right. Staff C said, I walked into the room, he was muddled, meaning he looked like he was not moving. I did a sternal rub, his feet were a little cold, and he was not responding. Staff C stated two CNAs (Staff A and B) were in the room. She said, I went to the nurse's station and called 911, and then I went and got the crash cart. Staff C stated she asked Staff B to go get the nurse from upstairs. Staff C said, I did not start CPR because I needed a back board. I was in the room waiting for the nurses to come and help put me put him on the board. He was a big guy, there is no way I could have moved him, I needed to have him on the floor. Staff C stated she did not ask the CNA to help her. Staff C said, I did not do compressions either. He was cold and he was dead. Staff C stated Resident #3 had oxygen on him. She said, He was gone. I did not call the code. Staff C stated the other nurses came pretty quickly. She said, We did not do anything. All of us stood there. Staff C stated within about 5 minutes (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the EMS were there. Staff C stated she had received training. She stated, Yes, I have been trained. If or when someone is in distress, you should call code blue, everyone should respond, get the crash cart and begin CPR. It did not happen for [Resident #3], I said because I believe he was gone, I am not certified to pronounce. Staff C stated Staff D, RN, was in the room. Staff C, LPN stated Staff D, RN should have started CPR or pronounced him. Staff C said, Not none of us did CPR. Everybody was in agreement he was gone and there was no way to bring him back. It was obvious. There was no AED (automated external defibrillator) to shock him or anything. We did not do anything. Staff C stated she gave a statement in writing to the DON. She stated her timeline was around 6:00 a.m., and a soon as she checked him, she called 911 with her personal cell phone which showed an outgoing phone call at 6:04 a.m. She denied having been notified at 5:30 a.m. that there was anything wrong with Resident #3. Staff C stated during the course of the night, she gave the resident medications between 9:00 p.m. and 9:30 p.m., snacks and cough drops. She said at 1:30 a.m. or 2:00 a.m. she saw him in bed, he was breathing. She said I checked the oxygen it was in his nares. Staff C confirmed Resident #3 was a full Code. She said, I did not perform CPR because he was cold. Staff C restated she needed someone to move him from the bed and put him to the board, and nobody tried to help her with that. Staff C, LPN said, He was a big guy. I just looked at him, he was gone. She stated when EMS came, they tried to work on him for 30 - 45 minutes and they could not bring him back either.On [DATE] at 12:14 p.m. a telephone interview was conducted with Staff D, RN. She stated she was, in charge per say. She said he was not my resident. She stated she was sitting at the desk when a Staff B, CNA came and said they needed an RN because, We need someone to pronounce someone who was dead. Staff D stated she and Staff E, LPN followed Staff B to the room. She stated Staff C walked in too. She said, I asked Staff C, LPN who they had called, and she said no one. I called the DON (Director of Nursing). Staff D stated the DON asked if the resident was a full code, and she confirmed and said, Yes. I yelled to them to start CPR. She said in that moment the paramedics came in. Staff D stated she had walked into the room when the CNA got her and observed him [Resident #3] laying on his back. She said she saw a table but does not remember there being a crash cart. Staff D said, I kept hearing they wanted me to pronounce the resident that was why I called the DON. Staff D, RN said their protocol if there was an unresponsive resident, is to check code status, and depending on the status act. If they are a full code, check pulse, check pupils, check for breathing, start CPR until the paramedics get there, and get a CNA to call Code. Staff D stated CPR was never done. She said, I do not know why it was not started. Staff D stated the for the reason she did not start CPR, She said, I did not start CPR myself because I did not know the code status, I assumed he was a DNR and that was why they were asking me to pronounce. I did not check myself. The whole time I was trying to figure out why. Staff D stated never been in that situation before. She stated she never had to pronounce anybody. She said, It is not our policy. Staff D stated not being told his code status. She said, I did not call the Code, the nurse should have told me. I had never pronounced a resident before. In my head I thought there was a change in policy I did not ask what his status was. I should have. Staff D, RN said she called the DON to find out what she wanted her to do about the pronouncing. She stated the DON said to check his code status and start CPR. Staff D, RN confirmed that night code blue was not called, and CPR was not started.On [DATE] at 1:05 p.m. a telephone interview was conducted with Staff E, LPN. She stated she would normally take care of Resident #3 on night shift. She stated when Resident #3 came to the facility, at first he was very confused but became alert over time. She said he slept intermittently and would be watching television. Staff E stated that night she was called by the CNA (Staff B) who said his nurse needed another nurse to come and pronounce a resident. She said the nurse who is an LPN needed an RN. She said the three of them got in the elevator and went to the room. Staff E stated Staff C was standing in the doorway, and she and Staff D, RN walked in. She stated Staff D checked the resident's pupils and respirations. She said Staff C came back in the room and Staff D asked Staff C if she had called the DON. Staff E stated Staff D, RN stepped out and she followed behind her. She stated Staff D called the DON and as she followed down the hall, she had (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	seen the paramedics coming. She stated it was approximately or around 6:00 a.m. Staff E stated she remembered herself and Staff D in the room at first. She said Staff C was not in the room. She said she remembered her coming in and telling Staff D the patient had been dead. Staff E said, While I was in the room we did not start CPR, I assumed because we did not know the code and the way the CNA presented it when she came to the 3rd floor, was that the nurse was needed to pronounce the resident deceased . Code blue was not called. No one started CPR. Staff E stated the facility protocol when a resident is found unresponsive is to call the code. She stated she had not done code blue before. She said normally as a nurse, she should assess the patient and check the code status. Staff E stated, For me, because the CNA said the nurse was needed to come and verify the resident was deceased , I assumed the resident was a DNR. Staff E stated she exited the room after that. She stated she had not participated in a code blue, or CPR. Staff E stated she was suspended pending the investigation.On [DATE] at 2:14 p.m. a telephone interview was conducted with the facility's Medical Director (MD). The MD stated having received a phone call the previous day and was told Resident #3 had died. The MD stated they said the aide checked on him at 6:00 a.m. and notified the nurse and they came and assessed him and within 2-3 minutes they called 911. The MD said his nurse got the other nurses to assist and then EMS arrived and that EMS started CPR. The MD stated the facility called her and spoke of the preliminary plan and was waiting for them to tell her when they were going to meet and discuss the issue. The MD said the expectation as the Medical director was that if a resident was unresponsive, there should be an immediate CPR started if they are a full Code. Chest compressions should start and have other people call the code and 911. She stated they did talk about the need for the staff to be educated on timeliness. The MD stated it was her understanding that the nurses were in the process of trying to get the board, and by that time there was no time for CPR to be initiated. The MD said, Nonetheless, with or without the board they should have started CPR. The MD stated they spoke about how long the patient was down and they could not tell. The MD stated how long the resident was down was good for documentation, but it should not matter. The MD stated they gave her a specific timeline. She said, I'm concerned if they failed to start CPR and were talking about pronouncing. Absolutely not, that is why we are having a. QAPI (quality assurance and performance improvement). The MD stated regarding failure to honor Resident #3's wishes, I wholeheartedly agree with you, the staff should have started CPR and then called 911. I do not know why the nurse said they did not do CPR and they did not tell me anything about the pronouncing. The MD stated it was not the facility's protocol to check if the feet were cold. The MD said this was not presented to her. The MD stated if the resident were a DNR, two nurses should have assessed the resident. The MD said, It is not our protocol for a nurse to pronounce. They should confirm code status. They should have initiated the CPR period. The MD stated this was an opportunity for education. She stated it was not their protocol for the nurse to determine if the resident had expired or not. The MD further stated not knowing Staff C, LPN had a similar situation in her past, where she did not initiate CPR on an unresponsive patient.On [DATE] at 2:09 p.m. an interview was conducted with the Regional Nuse Consultant (RNC), the Director of Nursing (DON) and the [NAME] President of Clinical Services, (VPCS). The RNC said, an allegation occurred after an all staff meeting on [DATE]. She stated Staff A, CNA said a resident was found unresponsive at 5:30 a.m. and the CNA felt the nurse did not do CPR. The RNC said at that point they filed the immediate report. She stated the immediate was too vague and it was kicked back. She stated they refiled the report that CPR was done by EMS, but not timely. She said they initiated an investigation on [DATE]. The RNC said they interviewed all the staff who were working and they were able to put together a timeline. The RNC stated their timeline revealed between 5:55 a.m. and 6:00 a.m., Staff B, CNA went in the room and about 6:00 a.m. found Resident #3 was not talking or arousing. The RNC stated they did not review the camera to confirm this timeline because the footage was no longer available. She stated Staff B, CNA went to the nurse, Staff C, LPN who was at the med cart and said Resident #3 did not seem right and could she check on him. She said the nurse reported she left the cart went to the room with the two (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and monitoring of residents with needs and behaviors which might lead to conflict or neglect;B. Ensuring the health and safety of each resident with regard to visitors such as family members or resident representatives, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions;C. Providing residents, representatives, and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed;D. Addressing features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur; andE. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors.The facility's immediate actions to remove the Immediate Jeopardy included: On [DATE] at 8:49 a.m. an internal investigation was initiated with resident record review, staff interviews, and notification to DCF, AHCA and local Law enforcement. On [DATE] Assigned nurse was suspended and terminated, with report of license to licensing board on [DATE] On [DATE]- two additional nurses that responded to the scene were suspended and terminated, with report of license to licensing board on [DATE] On [DATE] a complete facility audit was conducted by the Director of Clinical Services of resident code status preferences and verification of orders and care plans being correct. On [DATE] 100% audit of current residents was conducted by the Director of Clinical Services of the three crash carts in the facility to ensure that all required items were present. On [DATE] Ad Hoc QAPI meeting was held with Executive Director, Director of Clinical Services, Medical Director via telephone, and at least three other department heads. On [DATE] a review of facility deaths from the last 3 months were conducted by the Director of Clinical Services to ensure residents Advance Directives were followed related to Code Status. On [DATE] Implementation of the following:- Licensed nursing staff must sign Honoring Advance Directive Attestation upon hire.Staff Education On [DATE], Director of Clinical Services and/ or designee educated facility staff on the following:- Abuse, Neglect and Exploitation with the emphasis on Advance Directives. On [DATE] and [DATE] Director of Clinical Services and/or designee educated licensed staff on the following:- Honoring Advance Directives - Timeliness of initiated CPR- Following physician's orders - Code blue process. On [DATE] - All staff -Abuse, Neglect and Exploitation education with 100 percent completion On [DATE]- All staff- Resident Rights education- 100 percent completion On [DATE]- Licensed nursing staff received education with 100 percent completion on - Honoring Advance Directive Education, Physicians Orders Education, Timeliness of initiated CPR, and Code blue process. On [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] Director of Clinical Services and/or designee conducted code blue quality assurance drill. Licensed Nurse will not work prior to attending a mock code blue quality assurance drill. Verification of the facility's removal plan was conducted by the survey team on [DATE].On [DATE] interviews were conducted with 40 staff members, including 5 Registered Nurses, 7 Licensed Practical Nurses (LPNs),15 Certified Nursing Assistants (CNAs), and ancillary staff to include; therapy, dietary, housekeeping, social services, MDS nurse, Receptionist, and maintenance personnel. The staff members were able to state they had been trained and were knowledgeable about the facility policies regarding code status, their roles during a code blue, and where to find advanced directives. The staff members confirmed they had received abuse and neglect training.Based on verification of the facility's immediate jeopardy removal plan the immediate jeopardy was determined to be removed on [DATE] and the non-compliance was reduced to a scope and severity of D.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER Pinellas Park FL Opco, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8701 49th St N Pinellas Park, FL 33782	

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to honor a resident's expressed Advanced Directive for end of life by failing to ensure life saving measures of cardiopulmonary resuscitation (CPR) were performed, for one resident (#3) of two residents sampled. The failure to initiate CPR for approximately 35 minutes resulted in physical pain and ultimate death for Resident #3.This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to Resident #3 and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to a D after verification of removal of immediacy of harm.Cross reference to F600 and F726.Findings included: Review of the admission record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses to include Type 2 diabetes, other persistent atrial fibrillation, abnormal gait, need for assistance with personal care, blindness of Right eye, shortness of breath, muscle wasting, mood disorder and essential hypertension.Review of the physician order summary report for Resident #3 dated [DATE] revealed code status orders; Full Code, dated [DATE].Review of form 3008 (Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form) dated [DATE], revealed upon admission to the facility Resident #3 did not have a DNR (Do Not Resuscitate) order in place. The form revealed Resident #3 was alert, oriented, follows instructions and was capable to make healthcare decisions.Review of an Advanced Practical Registered Nurse (APRN) progress note revealed Advance Care Planning (ACP) occurred on [DATE]. The note read, Face to face conversation with patient for greater than 16 minutes to discuss ACP/GOC (goals of care) conversation. We had an extensive conversation concerning Full Code vs. (versus) DNR (Do Not Resuscitate) status. Patient verbalizes an understanding of the difference and elects/confirms Full Code status.Review of a physician progress note dated [DATE] revealed, Advanced Care Planning (ACP): Reviewed code status in the facility EMR (Electronic Medical Record) and discussed with patient. Verified ACP in the facility EMR. Code status - Full Code.Review of an admission/readmission nursing evaluation dated [DATE] revealed:15. code Status, Full Code - CPR. The neurological assessment revealed the resident was alert, oriented to person, place, time and situation. Resident #3 communicated appropriately with no obvious problems. Review of a care plan for Resident #3 initiated on [DATE] revealed a focus - Resident has an established advanced directive: Resident is Full Code. No other AD (Advanced Directive) on file. The goal indicated the resident or healthcare decision maker shall participate in decisions regarding medical care and treatment by next review date, initiated on [DATE]. Interventions included to allow opportunities for expression of feelings or concerns. Maintain signed consent and review annually. Promote opportunities for resident healthcare decision maker to participate in decisions regarding care.Review of a 5-day Minimum Data Set (MDS) for Resident #3 dated [DATE] revealed in Section B, the resident's speech was clear, makes self-understood and understands others. Section C revealed the resident had a brief interview for mental status (BIMS) score of 14, indicating intact cognition. Section GG revealed the resident required partial/moderate assistance for ADLs (Activities of Daily Living). Review of Resident #3's physician note dated [DATE] revealed: Resident was seen today for follow up on stability. He was seen in the chair on the hallway. Chart, MAR (medication administration record) and recent vitals reviewed. No acute issues or significant changes since last evaluation. Resident appears at baseline and remains clinically stable. No new complaints voiced. Current diagnosis and plan of care reviewed; no changes indicated at this time. Continue current treatments. POC (plan of care) was reviewed and discussed with the resident, nursing staff, and PCP (primary care physician). Denies fever, chills, SOB (shortness of breath). Code Status: Full Code. Review of a physician progress note dated [DATE], showed Resident #3's code status was Full Code.On [DATE] (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	at 11:14 a.m. a telephone interview was conducted with Staff A, CNA. Staff A stated Resident #3 was not assigned to her. She said she worked with Staff B, CNA, who had come to her hallway and stated her resident was not responding and he was not moving. She said this was around 5:30 a.m. Staff A said as she was walking down the hall she ran into Staff C, Licensed Practical Nurse (LPN) who was at the desk on the phone. She said she notified Staff C the resident was not responding and she said, Yes, I'm on my way, but she continued with what she was doing. Staff A said she went to the room and Staff B, CNA, was in the room. Staff A said Staff B was shaking Resident #3 and was calling his name. Staff A said, I checked his pulse on his arm and neck and he was not breathing. A few minutes later, the nurse, Staff C, came. She started calling him, I told her I did not get a pulse. She left to get a pulse oximeter. Staff A stated Resident #3 was laying on the bed, hanging on the side of the bed and one of the legs was off the bed. Staff A stated she and the other CNA, Staff B, positioned the resident back in bed. She said the nurse, Staff C came and put on the oximeter on the resident and his oxygen level was 60 (indicating moderate to severe hypoxemia, low blood oxygen). Staff A reported Staff C said, That is kind of low. Staff A said to the nurse, I said he is not here. Staff A stated she asked Staff C, Don't we need to call code?. Staff C said to hold on. She said let me go and check his status. Staff A stated Staff C left the room again and after a couple minutes she came and said [Resident #3] was a Full Code. Staff A stated, I said we need to start CPR. She said I should call another nurse. She said she did not know how to call the code. Staff A stated they were all standing there, waiting for her [Staff C, LPN] to tell them what to do. Staff A stated B, CNA asked, Do you want me to get another nurse? She stated Staff C did not answer so, at this point she said let me go. Staff A stated they all left the room, and she and Staff B went to get the RN (Registered Nurse) from upstairs. She said she took the stairs and Staff B took the elevator. She stated after she came downstairs she went to get the crash cart. Staff A stated Resident #3 was by himself during this time. She stated it was hard to tell how long it took. She said the time was moving slowly and fast at the same time. Staff A stated when she got to the room, the nurses, Staff D, RN, Staff E, LPN and Staff C, LPN all came in together. Staff A stated they were all in the room and Staff C was telling them what was happening. She said and the one nurse, Staff D, RN came and she was checking his oxygen and asking what happened. Staff A confirmed no one was doing CPR. She stated at this time the nurses took over. She said, I did not see anyone doing CPR. The nurses were asking us questions, they were from another floor. Staff A stated Staff D, RN said we needed to call 911. Staff A stated she asked Staff C if she had called, she said she was on her way down to call. Staff A stated she left the room together with Staff C and went to her assignment. She sated Staff B, CNA was very upset and she was trying to calm her down. She stated Staff B was saying maybe she could have done something different. Staff A stated she took Staff B to her assignment, and they started attending to her residents. Staff A stated the whole thing probably took about 15 minutes. She said they were in her hall when they heard the ambulance people coming up the stairs. She said they asked her where the room was. Staff A said, I believe it was around 5:45 a.m. now. She said she walked EMS (Emergency Medical Services) to Resident #3's room and left them in the room. Staff A said, When I walked in with EMS, I did not see anyone doing CPR. EMS asked what was going on. EMS asked for the paperwork for the resident, they asked, Why isn't anyone doing CPR if this man is a Full Code? Staff A stated she walked out of the room as EMS started CPR. She said later on, she gave a statement. Staff A said, I told them the truth. I said, code blue was not called and CPR was never initiated, not by our staff. Staff A, CNA stated having been suspended pending investigation.A telephone interview was conducted on [DATE] at 11:02 a.m. with Staff B, CNA, assigned to Resident #3. The CNA said, I found him [Resident #3] sometime close to 6:00 a.m. He was my resident. I went to the room and found him unresponsive. She stated she spoke to the nurse Staff C, LPN, she was on the med cart. Then she called another CNA, Staff A. Staff B stated Staff A went to the room with her and also tried to wake Resident #3 up. Then Staff C, LPN came. She stated Staff C, LPN said, He is not breathing. She said she needed another nurse, she said she did not know how to call the code on the intercom. Staff B (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated she ran upstairs and got another nurse. Staff B stated being new and had not done a code before. She said she went and got Staff E, LPN and Staff D, RN. She said they all went down to the room. Staff B stated she started to have a panic attack, so she left the room. She said she could not tell what was said or done. Staff B, CNA said, I did not observe anybody doing CPR. Staff B answered, No, I did not observe Staff B, LPN or the other nurses doing CPR. There was no paging, no one called code blue. I do not re-call any of that. Staff B stated Resident #3 was not fully dependent, he was an assist. She said If he had an accident she would change him. She stated he wore briefs at night and in morning he would be assisted to the bathroom. She stated they document after they provide care. She said there was no documentation because she did not toilet him at all that night. Staff B stated her shift started at 11:15 p.m. Staff B said, I checked on him earlier, around 4:00 a.m. and he was breathing, until sometime close to 6:00 a.m., not exactly 6:00 a.m. I found him unresponsive. Staff B stated time was moving fast and it was hard to tell what was happening.A telephone interview was conducted with Staff C, LPN on [DATE] at 11:36 a.m. Staff C was assigned to Resident #3 on [DATE]. She stated she only worked night shift and had taken care of the resident before. She said he was legally blind, he had cardiac issues, he always asked for snacks, was wearing oxygen, and he needed ADL (Activities of Daily Living) assistance. He could eat/drink by himself. His B/P (blood pressure) was okay as he was taking medications. Staff C, LPN said on that night it was around 1:20 a.m. or 2:00 a.m. when she changed a dressing on his roommate's leg. She said Resident #3 was sleeping, or I should say he appeared to be sleeping and in no distress. Staff C stated around 6:00 a.m. his CNA, Staff B came and said to take a look because he does not look right. Staff C said, I walked into the room, he was muddled, meaning he looked like he was not moving. I did a sternal rub, his feet were a little cold, and he was not responding. Staff C stated two CNAs (Staff A and B) were in the room. She said, I went to the nurse's station and called 911, and then I went and got the crash cart. Staff C stated she asked Staff B to go get the nurse from upstairs. Staff C said, I did not start CPR because I needed a back board. I was in the room waiting for the nurses to come and help put me put him on the board. He was a big guy, there is no way I could have moved him, I needed to have him on the floor. Staff C stated she did not ask the CNA to help her. Staff C said, I did not do compressions either. He was cold and he was dead. Staff C stated Resident #3 had oxygen on him. She said, He was gone. I did not call the code. Staff C stated the other nurses came pretty quickly. She said, We did not do anything. All of us stood there. Staff C stated within about 5 minutes the EMS were there. Staff C stated she had received training. She stated, Yes, I have been trained. If or when someone is in distress, you should call code blue, everyone should respond, get the crash cart and begin CPR. It did not happen for [Resident #3], I said because I believe he was gone, I am not certified to pronounce. Staff C stated Staff D, RN, was in the room. Staff C, LPN stated Staff D, RN should have started CPR or pronounced him. Staff C said, Not none of us did CPR. Everybody was in agreement he was gone and there was no way to bring him back. It was obvious. There was no AED (automated external defibrillator) to shock him or anything. We did not do anything. Staff C stated she gave a statement in writing to the DON. She stated her timeline was around 6:00 a.m., and a soon as she checked him, she called 911 with her personal cell phone which showed an outgoing phone call at 6:04 a.m. She denied having been notified at 5:30 a.m. that there was anything wrong with Resident #3. Staff C stated during the course of the night, she gave the resident medications between 9:00 p.m. and 9:30 p.m., snacks and cough drops. She said at 1:30 a.m. or 2:00 a.m. she saw him in bed, he was breathing. She said I checked the oxygen it was in his nares. Staff C confirmed Resident #3 was a full Code. She said, I did not perform CPR because he was cold. Staff C restated she needed someone to move him from the bed and put him to the board, and nobody tried to help her with that. Staff C, LPN said, He was a big guy. I just looked at him, he was gone. She stated when EMS came, they tried to work on him for 30 - 45 minutes and they could not bring him back either.On [DATE] at 12:14 p.m. a telephone interview was conducted with Staff D, RN. She stated she was, in charge per say. She said he was not my resident. She stated she was sitting at the desk when a Staff B, CNA came and said they (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	needed an RN because, We need someone to pronounce someone who was dead. Staff D stated she and Staff E, LPN followed Staff B to the room. She stated Staff C walked in too. She said, I asked Staff C, LPN who they had called, and she said no one. I called the DON (Director of Nursing). Staff D stated the DON asked if the resident was a full code, and she confirmed and said, Yes. I yelled to them to start CPR. She said in that moment the paramedics came in. Staff D stated she had walked into the room when the CNA got her and observed him [Resident #3] laying on his back. She said she saw a table but does not remember there being a crash cart. Staff D said, I kept hearing they wanted me to pronounce the resident that was why I called the DON. Staff D, RN said their protocol if there was an unresponsive resident, is to check code status, and depending on the status act. If they are a full code, check pulse, check pupils, check for breathing, start CPR until the paramedics get there, and get a CNA to call Code. Staff D stated CPR was never done. She said, I do not know why it was not started. Staff D stated the for the reason she did not start CPR, She said, I did not start CPR myself because I did not know the code status, I assumed he was a DNR and that was why they were asking me to pronounce. I did not check myself. The whole time I was trying to figure out why. Staff D stated never been in that situation before. She stated she never had to pronounce anybody. She said, It is not our policy. Staff D stated not being told his code status. She said, I did not call the Code, the nurse should have told me. I had never pronounced a resident before. In my head I thought there was a change in policy I did not ask what his status was. I should have. Staff D, RN said she called the DON to find out what she wanted her to do about the pronouncing. She stated the DON said to check his code status and start CPR. Staff D, RN confirmed that night code blue was not called, and CPR was not started.On [DATE] at 1:05 p.m. a telephone interview was conducted with Staff E, LPN. She stated she would normally take care of Resident #3 on night shift. She stated when Resident #3 came to the facility, at first he was very confused but became alert over time. She said he slept intermittently and would be watching television. Staff E stated that night she was called by the CNA (Staff B) who said his nurse needed another nurse to come and pronounce a resident. She said the nurse who is an LPN needed an RN. She said the three of them got in the elevator and went to the room. Staff E stated Staff C was standing in the doorway, and she and Staff D, RN walked in. She stated Staff D checked the resident's pupils and respirations. She said Staff C came back in the room and Staff D asked Staff C if she had called the DON. Staff E stated Staff D, RN stepped out and she followed behind her. She stated Staff D called the DON and as she followed down the hall, she had seen the paramedics coming. She stated it was approximately or around 6:00 a.m. Staff E stated she remembered herself and Staff D in the room at first. She said Staff C was not in the room. She said she remembered her coming in and telling Staff D the patient had been dead. Staff E said, While I was in the room we did not start CPR, I assumed because we did not know the code and the way the CNA presented it when she came to the 3rd floor, was that the nurse was needed to pronounce the resident deceased . Code blue was not called. No one started CPR. Staff E stated the facility protocol when a resident is found unresponsive is to call the code. She stated she had not done code blue before. She said normally as a nurse, she should assess the patient and check the code status. Staff E stated, For me, because the CNA said the nurse was needed to come and verify the resident was deceased , I assumed the resident was a DNR. Staff E stated she exited the room after that. She stated she had not participated in a code blue, or CPR. Staff E stated she was suspended pending the investigation.On [DATE] at 2:14 p.m. a telephone interview was conducted with the facility's Medical Director (MD). The MD stated having received a phone call the previous day and was told Resident #3 had died. The MD stated they said the aide checked on him at 6:00 a.m. and notified the nurse and they came and assessed him and within 2-3 minutes they called 911. The MD said his nurse got the other nurses to assist and then EMS arrived and that EMS started CPR. The MD stated the facility called her and spoke of the preliminary plan and was waiting for them to tell her when they were going to meet and discuss the issue. The MD said the expectation as the Medical director was that if a resident was unresponsive, there should be an immediate CPR started if they are a full Code. Chest (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	compressions should start and have other people call the code and 911. She stated they did talk about the need for the staff to be educated on timeliness. The MD stated it was her understanding that the nurses were in the process of trying to get the board, and by that time there was no time for CPR to be initiated. The MD said, Nonetheless, with or without the board they should have started CPR. The MD stated they spoke about how long the patient was down and they could not tell. The MD stated how long the resident was down was good for documentation, but it should not matter. The MD stated they gave her a specific timeline. She said, I'm concerned if they failed to start CPR and were talking about pronouncing. Absolutely not, that is why we are having a. QAPI (quality assurance and performance improvement). The MD stated regarding failure to honor Resident #3's wishes, I wholeheartedly agree with you, the staff should have started CPR and then called 911. I do not know why the nurse said they did not do CPR and they did not tell me anything about the pronouncing. The MD stated it was not the facility's protocol to check if the feet were cold. The MD said this was not presented to her. The MD stated if the resident were a DNR, two nurses should have assessed the resident. The MD said, It is not our protocol for a nurse to pronounce. They should confirm code status. They should have initiated the CPR period. The MD stated this was an opportunity for education. She stated it was not their protocol for the nurse to determine if the resident had expired or not. The MD further stated not knowing Staff C, LPN had a similar situation in her past, where she did not initiate CPR on an unresponsive patient.On [DATE] at 2:09 p.m. an interview was conducted with the Regional Nuse Consultant (RNC), the Director of Nursing (DON) and the [NAME] President of Clinical Services, (VPCS). The RNC said, an allegation occurred after an all staff meeting on [DATE]. She stated Staff A, CNA said a resident was found unresponsive at 5:30 a.m. and the CNA felt the nurse did not do CPR. The RNC said at that point they filed the immediate report. She stated the immediate was too vague and it was kicked back. She stated they refiled the report that CPR was done by EMS, but not timely. She said they initiated an investigation on [DATE]. The RNC said they interviewed all the staff who were working and they were able to put together a timeline. The RNC stated their timeline revealed between 5:55 a.m. and 6:00 a.m., Staff B, CNA went in the room and about 6:00 a.m. found Resident #3 was not talking or arousing. The RNC stated they did not review the camera to confirm this timeline because the footage was no longer available. She stated Staff B, CNA went to the nurse, Staff C, LPN who was at the med cart and said Resident #3 did not seem right and could she check on him. She said the nurse reported she left the cart went to the room with the two CNAs, Staff A and B and she checked the resident. The RNC said the nurse did a sternal rub, there was no pulse/respirations, and he was not breathing. The RNC stated Staff C reported she checked code status and confirmed Resident #3 was a full code. She stated in about 2-3 minutes, she told Staff B to go get the nurses upstairs as she called 911 from her personal cell phone and verified the 6:04 a.m. call. The RNC stated Staff C said she called and got the crash cart and then got to the resident's room. She stated per Staff E, LPN and Staff D, RN, they came downstairs along with Staff B, CNA. The RNC stated Staff D, RN did an assessment, checked for pulse and walked to the med cart and verified the code status and by this time the paramedics were right there, at 6:09 a.m. The RNC stated the EMTs (Emergency Medical Technicians) intubated him and worked on him for 45 minutes and they were not able to get a pulse. She stated they pronounced him and Staff C, LPN called the family and the doctor.During the interview on [DATE] at 2:41 p.m., the DON stated she had arrived to work about 7:00 a.m. for a scheduled townhall/staff meeting. She stated Resident #3 had already been pronounced. The DON stated she spoke to the nurse who said she had already called the family. The DON stated after the townhall/staff meeting, Staff A, CNA reported something went wrong with Resident #3. The DON said she immediately called the nurses and asked for statements. She stated she contacted the RNC and they started their investigation which included notifying DCF (department of children and families) and the police. The DON stated the EMTs started CPR.During the interview on [DATE] at 2:43 p.m., the RNC said regarding their findings, I think it was a very close time. I don't believe 5:30 a.m. is accurate even though the CNA reported that time. We believe the Nurse could have (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	paged code blue overhead, versus sending the CNAs upstairs. This could have saved time. The RNC stated Staff C, LPN was educated as she knew the process. The RNC said they reviewed the process and identified the problem was that Staff C, LPN did not call code and instead she sent the CNAs upstairs to get the nurses. The RNC said, The time is close, but they could have started CPR.On [DATE] at 2:45 p.m. the VPCS stated the nurses should have started CPR. She stated Staff C, LPN could have started compressions even if they were waiting for the board. She said, They elected not to. They had training prior to this process. They did not follow our policies and procedure. The VPCS said, They acted [NAME]. We will be reporting their licenses.Review of a facility policy titled, Cardiopulmonary Resuscitation (CPR), revised 1/2026, revealed, It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement guidelines regarding cardiopulmonary resuscitation (CPR).Policy Explanation and Compliance Guidelines:1. The facility will follow current American Heart Association (AHA) guidelines regarding CPR.2. If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and:a. In accordance with the resident's advance directives, orb. In the absence of advance directives or a Do Not Resuscitate order; andc. If the resident does not show obvious signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition).3. CPR certified staff will be available at all times.4. Staff will maintain current CPR certification for healthcare providers through a CPR provider whose training includes a hands-on session either in a physical or virtual instructor-led setting in accordance with accepted national standards.Review of a facility policy titled, Communication of Code Status, revised [DATE], revealed, It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information.a. Full Codeb. Do Not Resuscitatec. Do Not Intubated. Do not Hospitalize.The facility's immediate actions to remove the Immediate Jeopardy included: On [DATE] at 8:49 a.m. an internal investigation was initiated resident record review, staff interviews, notification to DCF, AHCA and local Law enforcement. On [DATE] Assigned nurse was suspended and terminated, with report of license to licensing board on [DATE]. On [DATE]- two additional nurses that responded to the scene were suspended and terminated, with report of license to licensing board on [DATE] On [DATE] a complete facility audit was conducted by the Director of Clinical Services of resident Code status preferences and verification of orders and care plans being correct. On [DATE] 100% audit of current residents was conducted by the Director of Clinical Services of the three crash carts in the facility to ensure that all required items were present. On [DATE] Ad Hoc QAPI meeting was held with Executive Director, Director of Clinical Services, Medical Director via telephone, and at least three other department heads. On [DATE] overheard page system instructions were placed by the telephones at the nurse's station, reception area and dining room with detailed instructions on how to page overhead by the Activities Director. On [DATE] a review of facility deaths from the last 3 months were conducted by the Director of Clinical Services to ensure residents Advance Directives were followed related to Code Status. On [DATE] Executive Director completed an audit of licensed nurse Licensure and Cardiopulmonary Resuscitation Cards were valid.Emergency Response Process Changes On [DATE] Implementation of the following: All new employees must participate in a Code Blue Drill upon hire Licensed nursing staff must sign a Honoring Advance Directive Attestation upon hireStaff Education: On [DATE], Director of Clinical Services and/or designee educated facility staff on Resident Rights' including the right to choose Code Status. On [DATE] and [DATE] Director of Clinical Services and/or designee educated licensed staff on the following:- Honoring Advance Directives- Timeliness of initiated CPR- Following physician's orders- Code blue process On [DATE] - All staff -Abuse, Neglect and Exploitation education with 100 percent completion On [DATE]- All staff- Resident Rights education- 100 percent completion On [DATE]- Licensed nursing staff received education with 100 percent completion on - Honoring Advance Directive Education, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinellas Park FL Opco, LLC	8701 49th St N Pinellas Park, FL 33782

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Physicians Orders Education, Timeliness of initiated CPR, and Code blue process. On [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE] Director of Clinical Services and/or designee conducted Code blue drill quality assurance drills. Licensed Nurse will not work prior to attending a mock code blue drillOn [DATE] interviews were conducted with 40 staff members, including 5 Registered Nurses, 7 Licensed Practical Nurses (LPNs), 15 Certified Nursing Assistants (CNAs), and ancillary staff to include: therapy, dietary, housekeeping, social services, MDS nurse, Receptionist, and maintenance personnel. The staff members were able to state they had been trained and were knowledgeable about the facility policies regarding Code status, their roles during a Code Blue, and where to find advanced directives. The staff members confirmed they had received abuse and neglect training.Based on verification of the facility's immediate jeopardy removal plan the immediate jeopardy was determined to be removed on [DATE] and the non-compliance was reduced to a scope and severity of D.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER Pinellas Park FL Opco, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8701 49th St N Pinellas Park, FL 33782	

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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	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure nursing staff demonstrated competency in ensuring life saving measures of cardiopulmonary resuscitation (CPR) were performed, for one resident (#3) of two residents sampled. The facility staff's failure to initiate CPR for approximately 35 minutes resulted in physical pain and ultimate death for Resident #3.This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to Resident #3 and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to a D after verification of removal of immediacy of harm.Cross reference to F600 and F678Findings included: Review of an undated facility job description titled, License Practical Nurse (LPN), revealed required qualifications included: current CPR certification.Major duties and responsibilities showed:Directs the daily activities of the certified nursing assistants (CNAs) in accordance with current federal, state and local regulations and guidelines and established facility policies and procedures.Follows the nursing model to promote holistic care for the residents.Ensures that policies and procedures are complied with by nursing personnel assigned.Collaborates with other members of the interdisciplinary team as needed to ensure residents' needs are holistically met.Participates in end-of-life care as required.Additional tasks include:Treats all residents with dignity and respect. Promotes and protects all residents' rights.Establishes a culture of compliance by adhering to all facility policies and procedures. Complies with standards of business conduct, and state/federal regulations and guidelines.Review of a physician progress note dated [DATE] showed Resident #3's code status was Full Code.On [DATE], Resident #3 was found unresponsive and with vital signs absent by facility staff and CPR was not performed. On [DATE] Resident #3 had a meeting with the facility's Advanced Practical Registered Nurse (APRN) and expressed his Advance Care wishes. The progress note read, We had an extensive conversation concerning full code vs. (versus) DNR (Do Not Resuscitate) status. Patient verbalizes an understanding of the difference and elects/confirms full code status. On [DATE] at 5:30 a.m., Resident #3 was found unresponsive by Staff A, CNA (Certified Nursing Assistant). Staff A notified his nurse, Staff C, Licensed Practical Nurse (LPN). Facility staff demonstrated incompetency by denying Resident #3 his right to be resuscitated as CPR was not initiated by facility staff. This failure to perform CPR resulted in Resident #3's death at the facility.On [DATE] at 11:14 a.m. a telephone interview was conducted with Staff A, CNA. Staff A stated Resident #3 was not assigned to her. She said she worked with Staff B, CNA, who had come to her hallway and stated her resident was not responding and he was not moving. She said this was around 5:30 a.m. Staff A said as she was walking down the hall she ran into Staff C, Licensed Practical Nurse (LPN) who was at the desk on the phone. She said she notified Staff C the resident was not responding and she said, Yes, I'm on my way, but she continued with what she was doing. She said the nurse, Staff C came and put on the oximeter on the resident and his oxygen level was 60 (indicating moderate to severe hypoxemia, low blood oxygen). Staff A reported Staff C said, That is kind of low. Staff A said to the nurse, I said he is not here. Staff A stated she asked Staff C, Don't we need to call code?. Staff C said to hold on. She said let me go and check his status. Staff A stated Staff C left the room again and after a couple minutes she came and said [Resident #3] was a Full Code. Staff A stated, I said we need to start CPR. She said I should call another nurse. She said she did not know how to call the code. Staff A stated they were all standing there, waiting for her [Staff C, LPN] to tell them what to do. She said, I did not see anyone doing CPR. The nurses were asking us questions, they were from another floor. Staff A stated Staff D, RN said we needed to call 911. Staff A said, I believe it was around 5:45 a.m. now. She said she walked EMS (Emergency Medical Services) to Resident #3's room and left them in the room. Staff A said, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pinellas Park FL Opco, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8701 49th St N Pinellas Park, FL 33782	

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When I walked in with EMS, I did not see anyone doing CPR. EMS asked what was going on. EMS asked for the paperwork for the resident, they asked, Why isn't anyone doing CPR if this man is a Full Code? Staff A stated she walked out of the room as EMS started CPR. She said later on, she gave a statement. Staff A said, I told them the truth. I said, code blue was not called and CPR was never initiated, not by our staff. Staff A, CNA stated having been suspended pending investigation.A telephone interview was conducted on [DATE] at 11:02 a.m. with Staff B, CNA, assigned to Resident #3. The CNA said, I found him [Resident #3] sometime close to 6:00 a.m. He was my resident. I went to the room and found him unresponsive. She stated she spoke to the nurse Staff C, LPN, she was on the med cart. Then she called another CNA, Staff A. Staff B stated Staff A went to the room with her and also tried to wake Resident #3 up. Then Staff C, LPN came. She stated Staff C, LPN said, He is not breathing. She said she needed another nurse, she said she did not know how to call the code on the intercom. Staff B, CNA said, I did not observe anybody doing CPR. Staff B answered, No, I did not observe Staff B, LPN or the other nurses doing CPR. There was no paging, no one called code blue. I do not re-call any of that. A telephone interview was conducted with Staff C, LPN on [DATE] at 11:36 a.m. Staff C was assigned to Resident #3 on [DATE]. She stated she only worked night shift and had taken care of the resident before. She said Resident #3 was sleeping, or I should say he appeared to be sleeping and in no distress. Staff C stated around 6:00 a.m. his CNA, Staff B came and said to take a look because he does not look right. Staff C said, I walked into the room, he was muddled, meaning he looked like he was not moving. I did a sternal rub, his feet were a little cold, and he was not responding. Staff C stated two CNAs (Staff A and B) were in the room. She said, I went to the nurse's station and called 911, and then I went and got the crash cart. Staff C stated she asked Staff B to go get the nurse from upstairs. Staff C said, I did not start CPR because I needed a back board. I was in the room waiting for the nurses to come and help put me put him on the board. He was a big guy, there is no way I could have moved him, I needed to have him on the floor. Staff C stated she did not ask the CNA to help her. Staff C said, I did not do compressions either. He was cold and he was dead. Staff C stated Resident #3 had oxygen on him. She said, He was gone. I did not call the code. Staff C stated the other nurses came pretty quickly. She said, We did not do anything. All of us stood there. Staff C stated within about 5 minutes the EMS were there. Staff C stated she had received training. She stated, Yes, I have been trained. If or when someone is in distress, you should call code blue, everyone should respond, get the crash cart and begin CPR. It did not happen for [Resident #3], I said because I believe he was gone, I am not certified to pronounce. Staff C stated Staff D, RN, was in the room. Staff C, LPN stated Staff D, RN should have started CPR or pronounced him. Staff C said, Not none of us did CPR. Everybody was in agreement he was gone and there was no way to bring him back. It was obvious. There was no AED (automated external defibrillator) to shock him or anything. We did not do anything. Staff C stated she gave a statement in writing to the DON. Staff C confirmed Resident #3 was a full Code. She said, I did not perform CPR because he was cold. Staff C restated she needed someone to move him from the bed and put him to the board, and nobody tried to help her with that. Staff C, LPN said, He was a big guy. I just looked at him, he was gone. She stated when EMS came, they tried to work on him for 30 - 45 minutes and they could not bring him back either.On [DATE] at 12:14 p.m. a telephone interview was conducted with Staff D, RN. She stated she was, in charge per say. She said he was not my resident. She said, I asked Staff C, LPN who they had called, and she said no one. I called the DON (Director of Nursing). Staff D stated the DON asked if the resident was a full code, and she confirmed and said, Yes. I yelled to them to start CPR. She said in that moment the paramedics came in. Staff D stated she had walked into the room when the CNA got her and observed him [Resident #3] laying on his back. She said she saw a table but does not remember there being a crash cart. Staff D said, I kept hearing they wanted me to pronounce the resident that was why I called the DON. Staff D, RN said their protocol if there was an unresponsive resident, is to check code status, and depending on the status act. If they are a full code, check pulse, check pupils, check for breathing, start CPR until the paramedics get there, and get a CNA to call (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Code. Staff D stated CPR was never done. She said, I do not know why it was not started. Staff D stated the for the reason she did not start CPR, She said, I did not start CPR myself because I did not know the code status, I assumed he was a DNR and that was why they were asking me to pronounce. I did not check myself. The whole time I was trying to figure out why. Staff D stated never been in that situation before. She stated she never had to pronounce anybody. She said, It is not our policy. Staff D stated not being told his code status. She said, I did not call the Code, the nurse should have told me. I had never pronounced a resident before. In my head I thought there was a change in policy I did not ask what his status was. I should have. Staff D, RN said she called the DON to find out what she wanted her to do about the pronouncing. She stated the DON said to check his code status and start CPR. Staff D, RN confirmed that night code blue was not called, and CPR was not started.On [DATE] at 1:05 p.m. a telephone interview was conducted with Staff E, LPN. Staff E stated that night she was called by the CNA (Staff B) who said his nurse needed another nurse to come and pronounce a resident. She said the nurse who is an LPN needed an RN. Staff E said, While I was in the room we did not start CPR, I assumed because we did not know the code and the way the CNA presented it when she came to the 3rd floor, was that the nurse was needed to pronounce the resident deceased . Code blue was not called. No one started CPR. Staff E stated the facility protocol when a resident is found unresponsive is to call the code. She stated she had not done code blue before. She said normally as a nurse, she should assess the patient and check the code status. Staff E stated, For me, because the CNA said the nurse was needed to come and verify the resident was deceased , I assumed the resident was a DNR. Staff E stated she exited the room after that. She stated she had not participated in a code blue, or CPR. Staff E stated she was suspended pending the investigation.On [DATE] at 2:14 p.m. a telephone interview was conducted with the facility's Medical Director (MD). The MD stated having received a phone call the previous day and was told Resident #3 had died. The MD said the expectation as the Medical director was that if a resident was unresponsive, there should be an immediate CPR started if they are a full Code. Chest compressions should start and have other people call the code and 911. She stated they did talk about the need for the staff to be educated on timeliness. The MD stated it was her understanding that the nurses were in the process of trying to get the board, and by that time there was no time for CPR to be initiated. The MD said, Nonetheless, with or without the board they should have started CPR. The MD stated they spoke about how long the patient was down and they could not tell. The MD stated how long the resident was down was good for documentation, but it should not matter. The MD stated they gave her a specific timeline. She said, I'm concerned if they failed to start CPR and were talking about pronouncing. Absolutely not, that is why we are having a. QAPI (quality assurance and performance improvement). The MD stated regarding failure to honor Resident #3's wishes, I wholeheartedly agree with you, the staff should have started CPR and then called 911. I do not know why the nurse said they did not do CPR and they did not tell me anything about the pronouncing. The MD stated it was not the facility's protocol to check if the feet were cold. The MD said, It is not our protocol for a nurse to pronounce. They should confirm code status. They should have initiated the CPR period. The MD stated this was an opportunity for education. She stated it was not their protocol for the nurse to determine if the resident had expired or not.On [DATE] at 2:09 p.m. an interview was conducted with the Regional Nuse Consultant (RNC), the Director of Nursing (DON) and the [NAME] President of Clinical Services, (VPCS). The RNC said, an allegation occurred after an all staff meeting on [DATE]. She stated Staff A, CNA said a resident was found unresponsive at 5:30 a.m. and the CNA felt the nurse did not do CPR. The RNC said the nurse did a sternal rub, there was no pulse/respirations, and he was not breathing. The RNC stated Staff C reported she checked code status and confirmed Resident #3 was a full code. She stated in about 2-3 minutes, she told Staff B to go get the nurses upstairs as she called 911 from her personal cell phone and verified the 6:04 a.m. call. The RNC stated Staff C said she called and got the crash cart and then got to the resident's room. She stated per Staff E, LPN and Staff D, RN, they came downstairs along with Staff B, CNA. The RNC stated Staff D, (continued on next page)

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	105422	A. Building B. Wing	03/05/2026

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN did an assessment, checked for pulse and walked to the med cart and verified the code status and by this time the paramedics were right there, at 6:09 a.m. The RNC stated the EMTs (Emergency Medical Technicians) intubated him and worked on him for 45 minutes and they were not able to get a pulse. She stated they pronounced him and Staff C, LPN called the family and the doctor.During the interview on [DATE] at 2:41 p.m., the DON stated she had arrived to work about 7:00 a.m. for a scheduled townhall/staff meeting. She stated Resident #3 had already been pronounced. The DON stated the EMTs started CPR.During the interview on [DATE] at 2:43 p.m., the RNC stated Staff C, LPN was educated as she knew the process. The RNC said they reviewed the process and identified the problem was that Staff C, LPN did not call code and instead she sent the CNAs upstairs to get the nurses. The RNC said, The time is close, but they could have started CPR.On [DATE] at 2:45 p.m. the VPCS stated the nurses should have started CPR. She stated Staff C, LPN could have started compressions even if they were waiting for the board. She said, They elected not to. They had training prior to this process. They did not follow our policies and procedure. The VPCS said, They acted [NAME]. We will be reporting their licenses. Review of a facility policy titled, Nursing Services and Sufficient Staff, revised 1/2026, revealed - It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment.Policy Explanation and Compliance Guidelines:4. The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for resident's needs as identified through resident assessments and described in the plan of care.5. Providing care includes, but is not limited to, assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.6. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.The facility's immediate actions to remove the Immediate Jeopardy included: On [DATE] at 8:49 a.m. an internal investigation was initiated resident record review, staff interviews, and notifications to DCF, AHCA and local Law enforcement. On [DATE] Assigned nurse was suspended and terminated, with report of license to licensing board on [DATE] On [DATE]- two additional nurses that responded to the scene were suspended and terminated, with report of license to licensing board on [DATE] On [DATE] a complete facility audit was conducted by the Director of Clinical Services of resident code status preferences and verification of orders and care plans being correct. On [DATE] residents whose preference was a Do Not Resuscitate Order was reviewed to ensure that a valid Florida DNRO is physically available at the facility. On [DATE] 100% audit of current residents was conducted by the Director of Clinical Services of the three crash carts in the facility to ensure that all required items were present. On [DATE] Ad Hoc QAPI meeting was held with Executive Director, Director of Clinical Services, Medical Director via telephone, and at least three other department heads. On [DATE] overheard page system instructions were placed by the telephones at the nurse's station, reception area and dining room with detailed instructions on how to page overhead by the Activities Director. On [DATE] a review of facility deaths from the last 3 months were conducted by the Director of Clinical Services to ensure residents Advance Directives were followed related to Code Status. On [DATE] Executive Director completed an audit of licensed nurse Licensure and Cardiopulmonary Resuscitation Cards were valid.Emergency Response Process Changes On [DATE] Implementation of the following: All new employees must participate in a Code Blue Drill upon hire Licensed nursing staff must sign an Honoring Advance Directive Attestation upon hireStaff Education On [DATE], Director of Clinical Services and/ or designee educated facility staff on Resident Rights' including the right to choose Code Status. On [DATE] and [DATE] Director of Clinical Services and/or designee educated licensed staff on the following:- Honoring Advance Directives- Timeliness of initiated CPR- Following physician's orders- Code blue process- Monthly (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	code drill will continue On [DATE] - All staff -Abuse, Neglect and Exploitation education with 100 percent completion On [DATE]- All staff- Resident Rights education- 100 percent completion On [DATE]- Licensed nursing staff received education with 100 percent completion on - Honoring Advance Directive Education, Physicians Orders Education, Timeliness of initiated CPR, and Code blue process. On [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] Director of Clinical Services and/or designee conducted code blue quality assurance drill. Licensed Nurse will not work prior to attending a mock code blue quality assurance drill. On [DATE] interviews were conducted with 40 staff members, including 5 Registered Nurses, 7 Licensed Practical Nurses (LPNs),15 Certified Nursing Assistants (CNAs), and ancillary staff to include; therapy, dietary, housekeeping, social services, MDS nurse, Receptionist, and maintenance personnel. The staff members were able to state they had been trained and were knowledgeable about the facility policies regarding code status, their roles during a code blue, and where to find advanced directives. The staff members confirmed they had received abuse and neglect training.Based on verification of the facility's immediate jeopardy removal plan the immediate jeopardy was determined to be removed on [DATE] and the non-compliance was reduced to a scope and severity of D.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interviews the facility failed to maintain complete and accurate medical records related to documentation of activities of daily living (ADLs) for one resident (#2) out of two residents reviewed.Findings included: A review of Resident #2's admission record revealed an admission date of 11/21/25 and a discharge date of 11/24/25, with diagnoses to include Parkinson's disease, sarcopenia, cognitive communication deficit, dementia, personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits.A review of Resident #2's toileting task from 11/21/25-11/24/25 revealed there was no documentation showing Resident #2 had received incontinence care during 8 out of10 opportunities.A review of Resident #2's nutrition/eating task from 11/21/25-11/24/25 revealed there was no documentation showing Resident #2 received their meals 7 out of 9 opportunities.During attempted interviews conducted with staff on 3/4/26 and 3/5/26, they revealed they did not remember who the resident was due to the short stay and could not speak of the care that was provided.An interview conducted on 3/5/26 at 1:36 p.m. with the Director of Nursing (DON) revealed she was not familiar with this resident. She stated documentation should verify if care was provided or not. The DON said it was her expectation for staff to provide incontinent care to residents. The DON stated there was no reason for any of the care opportunities to be blank. The DON said reviewing the record, she was unable to be determine if the resident received incontinence care and meals as expected, because there was no documentation or refusal of the same. The DON stated she expected staff to provide timely care and services and document accordingly.A review of Resident #2's quarterly Minimum Data Set (MDS) assessment, dated 11/27/25 section C - cognitive patterns revealed a Brief Interview Mental Status (BIMS) score of 04, indicating severe impairment. Resident #2's section GG- Functional abilities revealed the resident scored a 01-meaning the resident was dependent- Helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity for toileting hygiene. A review of Resident #2's section H- Bladder and Bowel revealed the resident scored a 3-Always incontinent (no episodes of continent voiding) for both bowel and urinary continence. A review of Resident #2's care plan dated 11/21/25 revealed Resident #2 had a potential/actual impairment to skin integrity related to decreased cognition, decreased mobility, incontinence, pain, and weakness. The interventions included to keep skin clean and dry. There were no documented behaviors of refusing care.A review of the facility's incontinence policy revealed the following: Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible.A review of the facility's policy titled Activities of Daily Living (ADLs) revealed the following: Care and services will be provided for the following activities of daily living: Toileting . A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility will maintain individual objectives of the care plan and periodic review and evaluation.A review of the facility's policy, Serving a Meal, revealed the following: It is the policy of this facility to serve meals that meet the nutritional needs of residents. Diets should be served in accordance with the physician's order. Prepare the room or serving area for mealtime (decrease noise level, provide lighting, position comfortably) and make sure hands and face are clean. Place tray on dining table or overbed table if the resident eats in their room. Check on the resident at regular intervals. Alternate foods, readily available foods, or supplements should be offered, in accordance with diet restrictions, when a resident consumes less than half of the meal.The facility did not provide a policy on documentation.