

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Aviata at Arbor Springs		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 SE 24th Rd Ocala, FL 34471	
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy and procedure review, the facility failed to act in accordance with a resident's advance directive and to honor the resident's wishes of Do Not Resuscitate (DNR) for 1 of 3 reviewed residents, Resident #6, when found unresponsive and absent of life. This has the potential to affect 42 residents with advance directives of Do Not Resuscitate. Findings include: Review of Resident #6's admission record showed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses to include acute embolism and thrombosis of right subclavian vein, acute embolism and thrombosis of right internal jugular vein, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus without complications, morbid (severe) obesity due to excess calories, hemiplegia and hemiparesis following cerebral infarction affecting unspecified side, generalized muscle weakness, dyspnea, unsteadiness on feet, recurrent mild major depressive disorder, generalized anxiety disorder, anemia, hyperlipidemia, essential (primary) hypertension, paroxysmal atrial fibrillation, unspecified diastolic (congestive) heart failure, occlusion and stenosis of unspecified carotid artery, stage 3 chronic kidney disease, dependence on renal dialysis, presence of automatic (implantable) cardiac defibrillator, and acute respiratory failure with hypoxia. Review of Resident #6's State of Florida Do Not Resuscitate Order read, Being informed of my right to refuse cardiopulmonary resuscitation (CPR), including artificial ventilation, cardiac compression, endotracheal intubation, and defibrillation, direct that CPR be withheld or withdrawn from me. The form was signed by Resident #6 and Staff P, Advanced Practice Registered Nurse (APRN) on [DATE]. Review of Resident #6's physician order dated [DATE] read, Order Type: Advanced Directive. Order Summary: Do NOT Resuscitate. Review of Resident #6's nursing progress note authored by Staff A, Licensed Practical Nurse (LPN), dated [DATE] at 8:31 AM read, Resident returned on the unit from HD [hemodialysis] at approximately 8:30 am via transport. Upon arrival, resident was awake, alert, and noted to be conversing appropriately with the CNA's [certified nursing assistants] during transport back to her room. Resident continued speaking with staff members throughout the transfer from the transport chair to bed. Transfer was completed without incident, and resident tolerated transfer well. Review of Resident #6's nursing progress note authored by Staff A, LPN, dated [DATE] at 8:50 AM read, Late Entry. Note Text: Resident noted unresponsive at 8:40 am. At 8:40 am [Staff F, Registered Nurse (RN)'s name] initiated chest compressions, EMS [Emergency Medical Service] arrived at 8:45 am and assumed resident care. Time of Death 8:50 am. Review of Resident #6's nursing progress note authored by the Director of Nursing on [DATE] at 8:54 AM read, Resident time of death called at 08:50 am by EMS. MD [Medical Doctor] notified and order received to release resident remains to funeral home of family choosing. Daughter arrived at facility at 09:10 am. Resident daughter was informed that CPR was performed. Daughter was ok with this information and (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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	went to stay with her mom until the funeral home arrived. Review of the witness statement authored by Staff A, LPN, dated [DATE] read, Around 8:40 AM this writer was called by two CNA's to [Resident #6's room number] resident noted unresponsive upon entering the room, myself and another nurse [Staff F, RN's initials] assessed resident and asked the primary nurse [Staff E, LPN's first initial] resident code status. Informed full code, so code blue was called and initiated. Review of the witness statement authored by Staff A, LPN, dated [DATE] read, [Staff F, RN's name] and another nurse did CPR. AED was applied and no shock applied. I left the room and checked resident's chart for her code status red chart noted resident's name and DNR gold paper inside. I returned back to the room and informed the nurses that the resident is a DNR. I overheard someone saying that since 911 was called we have to continue CPR until they arrive, which we did. Review of the witness statement authored by Staff A, LPN, dated [DATE] read, I was standing by the nurses station around 8:35 AM, 2 CNAs came to the nurses station saying [Resident #6's name] is unresponsive right after we transferred her to bed. I dropped what I was doing and ran to [Resident #6's room number]. [Staff F, RN's name] was already in [Resident #6's room number] assessing [Resident #6's name]. Resident had shallow breathing during assessment, no pulse or respirations noted. Primary nurse [Staff E, LPN's name] what is resident code status, [Staff E, LPN's name] said full code and walked out of the room. When we heard full code, I said out loud this is a code blue. Someone overhead paged and [Staff F, RN's name] and all of the nurses came with the crash cart. Review of the witness statement authored by Staff E, LPN, dated [DATE] read, On request I went to verify the resident's code sheet after reviewing the resident's record I confirmed that the resident's code status was a DNR and immediately communicated the information. That time I instructed another nurse to accompany me or follow me to verify the code status. After I communicated the resident's DNR status, I observed that CPR was subsequently performed despite my communication. Also another nurse stated that the resident was DNR and I say that because compressions had already been started they had to continue on. Review of the witness statement authored by Staff F, RN, dated [DATE] read, Code blue was called and I jumped into action after I heard full code. We started performing CPR until EMS arrived. The nurse stated that the patient was a full code, code blue was activated and we nursing staff started to perform CPR. Review of the witness statement authored by Staff F, RN, dated [DATE] read, I was cleaning the wound cart when [Staff D, CNA's name] called my name and [Staff A, LPN's name] to check on the patient because she was unresponsive. [Staff A, LPN's name] got there first and I assisted her with my pulse oximeter. Initially while the sternal rub was on going sats [oxygen saturation] were at 72% with a pulse of 150's. As soon as the sternal rub was stopped the pulse dropped to 30's to 40's. The nurse [Staff E, LPN's name] who was with [Staff D, CNA's name] headed out to check the patient code status and came back and stated full code. Compressions were started after the attestation performed by [Staff A, LPN's name] requested in that the patient has no sign of life, no pulse, no respirations. Next thing I saw was [Staff A, LPN's name] calling code blue. Some staff came to the room with the crash cart and [Staff A, LPN's name] was putting the resident on CPR board. When [Staff A, LPN's name] finished putting the patient, she called to start compressions. As I did the first round, while [Staff A, LPN's name] used Ambu bag and placed patches for the AED. AED started, then we all stepped back. Another nurse took over compressions and [Staff G, LPN's name] the Ambu bag. I stepped back then the nurses started compressions, along with [Staff G, LPN's name]. They completed the round and switched positions. I headed to the hall and when I looked back, [Staff E, LPN's name] and [Staff K, LPN's name] were next to the patient and [Staff L, CNA's name] was writing on the board everything that happened. I was next to the door when EMS arrived. EMS took over, some staff stopped next to the room and I (continued on next page)		

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	that.During an interview on [DATE] at 2:56 PM, Staff D, CNA, stated, I was walking past, and saw [Resident #6's name] on the [brand name of the mechanical lift device] lift. I walked into the room and asked if they needed help. As they were putting her down on the bed, I noticed [Resident #6's name] didn't look right. She was not responding. I said [Staff B, CNA's name], [Resident #6's name] don't look good. I went and got the nurse, [Staff E, LPN's name]. I heard [Staff E, LPN's name] say she was a DNR when she walked in the room with the blood pressure cuffs. I left the room after that.During an interview on [DATE] at 3:05 PM, Staff C, CNA, stated, We went and picked up [Resident #6's name] from dialysis. It was earlier than usual. They had her already sitting by the door when we got there. The nurse knew we were taking her. We passed [Staff A, LPN's name] in the hallway coming up 500 hall she was headed to dialysis because she said they had called her and asked for some medication for her. We got her hooked up in the [brand name of the mechanical lift device], lifted and put her over the bed. As we were lowering her, she let out a deep sigh and then became unresponsive while the [brand name of the mechanical lift device] pad was still under her. [Staff B, CNA's name] was calling her name, she wasn't responding, and [Staff B, CNA's name] told me to get the nurse. I looked for [Staff A, LPN's name], she was the supervisor. I saw [Staff E, LPN's name] on the med cart and told her [Resident #6's name] was unresponsive. [Staff E, LPN's name] got the vital sign equipment and headed to the room. I saw [Staff F, LPN's name] behind the nurses' station at 600 hall. I told him that she was unresponsive and he headed toward the room. I saw [Staff A, LPN's name] coming up the 500 hall, and I let [Staff A, LPN's name] know the patient was unresponsive and she headed toward the room. I did not go back into the room after that, I left.During an interview on [DATE] at 4:15 PM, the Director of Nursing stated, I was not here the day [Resident #6's name] coded. It was a Saturday. Around 9 AM, my phone started blowing up. The unit manager called me, [Staff A, LPN's name] called me, and the wound care nurse [Staff I, LPN's name] called me. They were telling me the resident was coming back from dialysis, they were putting her back to bed and she became unresponsive and they did CPR and that she had a DNR. At that point, I knew there was an error.During an interview on [DATE] at 5:08 PM, Staff I, LPN, stated, I saw [Staff E, LPN's name] doing chest compressions. EMS arrived and took over care of the patient. CPR was stopped. I notified the DON and asked what education I needed to start on.During an interview on [DATE] at 9:16 AM, Staff L, CNA, stated, We were down in the wound care area and heard the code over the intercom. I went up there. I peeked in the room and made sure they had the crash cart in the room. They did. I saw [Staff F, RN's name], [Staff A, LPN's name], and [Staff E, LPN's name]. [Staff F, RN's name] was doing compressions. Once I saw everyone was in there, I stood in the hallway and waited for EMS to arrive. It was not very long before EMS got there.During an interview on [DATE] at 9:31 AM, Staff O, Assistant Director of Nursing (ADON), stated, I was not here the day of [Resident #6's name]'s code. The information I have is that she came from dialysis, CNAs were putting her back to bed. She did not look right. I believe nurse [Staff E, LPN's name] came in, they asked what the code status was. They were told she was a full code, so they started CPR. After CPR was initiated, they were made aware she was a DNR. They thought that once you start CPR, you cannot stop until EMS gets there. As far as I knew at the time, once you initiate CPR, you can't stop until EMS gets there. If a patient is found unresponsive, the first thing you do after you assess is to check the code status in the red charts. Two nurses must verify the code status before CPR is initiated.During an interview on [DATE] at 9:47 AM, Staff F, RN, stated, I remember I was cleaning the wound care cart. One of the CNAs called my name. [Staff A, LPN's name] and [Staff E, LPN's name] went to the room. We took vitals on the patient. They called code blue and we all went back in the room. [Staff A, LPN's name] put her on the CPR board. Nurse [Staff E, LPN's name] said she (continued on next page)		

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a DNR, but that we couldn't stop CPR until EMS got there. Afterwards [Staff A, LPN's name] pulled me to the side and said she didn't hear that I said the resident was DNR. During an interview on [DATE] at 3:45 PM, Staff G, LPN, stated, At the time of the code, I was passing meds. I ran to the room, [Staff H, LPN's name] went to the room and [Staff E, LPN's name] was in the room. [Staff F, RN's name] was giving compressions and [Staff A, LPN's name] was in there. I grabbed the oxygen tank and [Staff E, LPN's name] grabbed the Ambu bag. [Staff A, LPN's name] showed me how to hook up with Ambu bag. [Staff H, LPN's name] relieved [Staff F, RN's name] and began doing chest compressions. After she was finished, I was doing the Ambu bag. [Staff E, LPN's name] left the room, and then came back. Everyone came in and someone hooked up the AED. After that, [Staff E, LPN's name] left and came back in, then [Staff A, LPN's name] left and came back in and said she needed to speak to [Staff E, LPN's name] when we were finished. Then she said the resident was a DNR, but we have to keep running the code until EMS came. Review of the facility policy and procedure titled Advanced Directives with the last review date of [DATE] read, Policy: The center will abide by state and federal laws regarding advance directives. The center will honor all properly executed advance directives that have been provided by the resident and/or resident representative. Review of the facility policy and procedure titled Florida Cardiopulmonary Resuscitation (CPR) with the last review date of [DATE] read, Policy: Cardiopulmonary Resuscitation (CPR) will be provided to all residents who are identified to be in cardiac arrest unless such resident has a fully executed Florida Do Not Resuscitate (DNR) order. Procedure: 1. In the event of cardiac arrest, immediately call for assistance. 2. Two licensed nurses are to verify: Resident identification. Fully executed Florida Do Not Resuscitate order (DH1896), located in the advanced directive section of the medical record. The Immediate Jeopardy (IJ) was removed on [DATE]. The facility administration initiated an investigation regarding the incident On [DATE] and completed the investigation on [DATE]. On [DATE], the facility held an Ad Hoc QAPI (Quality Assurance and Performance Improvement) meeting and conducted a root cause analysis to develop a performance improvement plan. Root cause analysis identified as failure of staff to follow facility policy on verification of code status. On [DATE], 85% of licensed nurses and CNAs completed education on advance directives, resident rights, CPR/DNR, and abuse and neglect. On [DATE], 85% of licensed nurses and CNAs participated in code blue drills that was initiated on [DATE] for every 12 hours. On [DATE], 85% of licensed nurses competency for CPR/DNR were validated and verified through post testing. During interviews conducted on [DATE] through [DATE], 25 CNAs, 12 LPNs, 3 RNs, the Maintenance Director, the Appointment Scheduler, the Director of Patient Experience, and the Director of Central Supply stated that they had received training for abuse, neglect, and exploitation, resident rights, verification of advance directives with two nurses, and code blue training. All interviewed staff members confirmed their understanding of the training, how to verify code status with two nurses, and the location of advanced directives. All interviewed staff members stated that they have participated in code blue drills. The facility corrected the non-compliance as of [DATE]. The facility conducted 100% audit of all current residents' code status for accuracy. All licensed nurses and CNAs completed education on advance directives, resident rights, CPR/DNR, and abuse and neglect, participated in code blue drills, and completed competency verification by [DATE]. The facility conducted weekly audits of all newly admitted residents to ensure accuracy of advance directive status and to verify the nurse competency on advance directives. The facility conducted Ad Hoc QAPI meetings on [DATE], [DATE] and [DATE] to review the effectiveness of the corrective action plan.		

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NAME OF PROVIDER OR SUPPLIER Aviata at Arbor Springs		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 SE 24th Rd Ocala, FL 34471	
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to ensure a resident' concern regarding false statement by a staff member was filed as a grievance and investigated for 1 of 3 reviewed residents (Resident #8).Findings include:During an interview on 7/28/2026 at 9:50 AM, Resident #8 stated that he went to Social Services Director and reported that he had assisted his roommate following a fall and that a Certified Nursing Assistant (CNA) subsequently stated that the resident had not assisted her. The CNA's statement was false and that no one investigated his allegation and after speaking with Social Services Director, the Social Services Director approached him and asked whether he wanted to transfer because he was unhappy with the facility. The resident stated that he did not want to transfer and wanted to remain at the facility.Review of the facility's grievance log showed a grievance filed by Resident #8 on 4/8/2026 concerning inconsistent care. There was no grievance related to staff member's false statement.During an interview on 7/27/2026 at 1:55 PM, the Assistant Director of Nursing (ADON) stated, I don't know why a grievance was not filed. It should have been. The ADON further stated that she spoke with Resident #8 and removed the CNA from providing care to the resident.During an interview on 7/27/2026 at 11:32 AM, the Social Services Director stated that she was not aware of a grievance being filed by Resident #8 other than the grievance dated 4/8/2026. She stated that Resident #8 came to her office and reported that he had assisted his roommate after the roommate fell and that he had shoulder pain and he was unhappy with how the staff was treating him. The Social Services Director further stated that since Resident #8 had previously (January 2026) expressed a desire to be closer to his wife and because the resident was unhappy with the services at the facility, she asked whether he still wanted her to attempt to transfer him closer to his wife. The social services director stated, I did not fill out a grievance. That is not how grievances work.During an interview on 7/28/2026 at 2:25 PM, the Director of Nursing stated, A grievance should have been filed, investigated, and followed up in writing.Review of the facility policy and procedure titled Complaint/grievance dated 1/15/2026 read, The Center will support each resident's right to voice a complaint/grievance without fear of discrimination or reprisal. The center will make prompt efforts to resolve the complaint/grievance and inform the resident of progress towards resolution. Procedure: 1. An employee receiving a complaint/grievance from a resident family member and/or visitor will initiate a complaint/grievance form. 2. Original grievance forms are then submitted to the grievance officer/designee for further action. 3. The grievance officer/designee shall act on the grievance and begin follow-up of the concern or submit it to the appropriate department director for follow-up. 4. The grievance follow-up should be completed in a reasonable time frame; this should not exceed 14 days. 5. The findings of the grievance shall be recorded on the complaint/grievance form. 6. The results will be forwarded to the Executive Director for review and filing. 7. The Grievance official will log complaints/grievances in monthly grievance log. 8. The individual voicing the grievance will receive follow up communication with the resolution, a copy of the grievance resolution will be provided to the resident upon request.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the provided services met professional standards of quality by allowing a resident to self-administer medications without a physician's order and without assessing the resident's ability to safely self-administer medications for 1 of 3 residents reviewed for medication administration (Resident #5). Findings include: During an interview on 7/27/2026 at 10:00 AM, Resident #5 stated, I do dialysis here every Tuesday, Thursday and Saturday. I have been here for about two weeks. They have not had my binders until today. They didn't have the binders, so I had to get permission to bring my binders in from home and take those. Review of Resident #5's admission record showed the resident was admitted on [DATE] with diagnoses to include other specified complication of vascular prosthetic devices, implants, and grafts; end stage renal disease; dependence on renal dialysis; acquired arteriovenous fistula; type 2 diabetes mellitus; muscle weakness; hypertensive chronic kidney disease; chronic atrial fibrillation; other disorders of phosphorus metabolism; gastroesophageal reflux disease; and gout. Review of Resident #5's physician order dated 7/1/2026 read, Calcium Acetate Oral Tablet 667 MG [milligram] (Calcium Acetate (Phosphate Binder)), Give 2 tablet by mouth three times a day every Mon [Monday], Wed [Wednesday], Fri [Friday], Sun [Sunday] for phosphate binder. Review of Resident #5's physician orders showed no order for self-administration of medications. Review of Resident #5's care plan showed no care plan focus or interventions for self-administering medications. During an interview on 7/30/2026 at 9:44 AM, Staff Q, Registered Dietician, stated, Some of the medications come bundled from the dialysis center, depending on their insurance. The dialysis dietician started last month. I believe the resident wasn't supposed to be here for a long time. I remember there was some issue with his binders, and the dialysis RD [Registered Dietician], the DON [Director of Nursing], and I spoke about it. But I do not remember the exact situation. During an interview on 7/30/2026 at 10:18 AM, the Director of Nursing stated, I was not aware that [Resident #5's name] was taking his home medication. He does not have orders to self-administer medications and was not care planned for self-administration of medications. He did not get permission from me. I am not sure who would have given permission for that. There is a process we have to do before that can happen. The process is that if a resident wants to self-administer, we do an assessment, if the assessment says they are cognitively able to do it, and able to verbalize their medication treatment times and everything about the medication. If they are able to do that, we have to create a journal or log for the resident to document in when they take their medications. We also have to get a locked box to keep the medications in. Then we have to care plan them for self-administration, and there needs to be an order. Review of the facility policy and procedure titled Self-Administration of Medication at Bedside reviewed on 1/15/2026 read, Policy: The resident may request to keep medications at bedside for self-administration in accordance with Resident Rights. Criteria must be met to determine if a resident is both mentally and physically capable of self-administering medication and to keep accurate documentation of these actions. Procedure: Verify physician's order in the resident's chart for self-administration of specific medications under consideration. Complete Self-administration of Medications Evaluation. The Interdisciplinary Team will review the evaluation and will document Section III. Approval granted must be checked yes or no. Interdisciplinary team member signs the evaluation section. If approval is not granted, a statement must be written as to reason for denial. Complete the Care Plan for approved self-administered drugs. The MAR [Medication Administration Record] must identify meds that are self-administered and the medication nurse will need to (continued on next page)		

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow-up with resident as to documentation and storage of medication during each med pass. If kept at bedside, the medication must be kept in a locked drawer.		