

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Heritage Park Health Center by Harborview		STREET ADDRESS, CITY, STATE, ZIP CODE 2302 59th St W Bradenton, FL 34209	
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 - Minimal harm or potential for actual harm 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 record review, interviews, and review of facility policy, the facility failed to ensure staff administered CPR (Cardiopulmonary Resuscitation) in accordance with professional standards of practice and the facility's CPR policy, for one resident (#1) of two residents reviewed. The facility staff did not call a Code Blue, did not activate EMS (Emergency Medical Service), did not utilize the crash cart or emergency equipment, and did not provide CPR continuously as required for a resident with a full code status. Findings Included: On [DATE] at 10:56 AM, a phone interview was conducted with Staff A, Licensed Practical Nurse (LPN). Staff A stated on [DATE], Staff B, Certified Nursing Assistant (CNA), advised them Resident #1 was not breathing. Staff A stated upon arriving to Resident #1's room, they checked Resident #1's pulse and, when no pulse was found, they started CPR. Staff A stated the family member said Resident #1 had stopped breathing around 11:12 AM. Staff A stated while they were performing CPR, the family member asked why CPR was being done since the resident had already passed away, and Staff A advised the family member they had to continue CPR until EMS arrived. Staff A stated after about 15 minutes, they stopped performing CPR to get Staff B to be a witness and help clean up the resident. Once Staff A and Staff B returned to the room, Staff A stated they began CPR a second time. Staff A stated they did not call a Code Blue because the family member made them nervous and acknowledged they did not follow the facility's CPR policy, adding they did not know why they did not call a Code Blue or why they stopped CPR. On [DATE] at 11:47 AM, a phone interview was conducted with Staff B, CNA. Staff B stated they were in Resident #1's room feeding the roommate when the family member said Resident #1 was not breathing. Staff B stated they found Staff A, who was transporting another resident, and informed them of the situation. Staff B stated they took over Staff A's task so Staff A could check Resident #1. Staff B stated when they saw Staff A about 20 minutes later, Staff A advised them to get washcloths and help clean up Resident #1. Staff B stated Staff A asked the family member for the time and then called the time of death. Staff B stated they did not see Staff A perform CPR but were told by Staff A CPR had been done while they were writing their statements. Staff B stated they did not know who called 911 and were not instructed to call a Code Blue. Staff B stated they received no guidance on performing CPR, code status, or what to do when there is a Code Blue and believed only nurses could call a Code Blue. Staff B stated Staff A never advised them to call a Code Blue for Resident #1. On [DATE] at 12:06 PM, an interview was conducted with Staff C, LPN, who was assigned to the south end of the unit and did not provide care to Resident #1 day. Staff C stated Staff A did not mention Resident #1 passing until later in the day when asking what to do regarding after-death care. Staff C stated they were never called to assist and never heard a Code Blue called. Staff C stated they told Staff A they should have notified others so assistance could have been provided. Staff C stated they were unaware a code situation had occurred until more than an hour after the incident. Staff C stated they did not see the crash cart outside Resident #1's room; instead, they saw it in the utility room with nothing removed or documented as used. Staff C stated the Ambu bag should have been removed during a Code Blue but was not. Staff C stated hospice residents receive the same lifesaving (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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions as any other resident unless they have a DNR (Do Not Resuscitate) order, and confirmed Resident #1 was not a DNR at the time. Staff C stated when a resident is unresponsive, the aide notifies a nurse, who then checks code status and follows the facility's Code Blue protocol. On [DATE] at 2:16 PM, an interview was conducted with Resident #1's primary care provider (PCP). The PCP stated Staff A stepped outside their training, broke the facility's system, and acted independently. The PCP stated when a resident is full code, the process includes checking code status, initiating CPR, calling 911, and continuing compressions until EMS arrives. The PCP stated they believed staff were trained and did not know why the system was not followed. The PCP stated EMS would then determine next steps in consultation with an ER provider. The PCP stated Staff A did not appear to have participated in many required steps and reiterated the expectation to follow standard of care when advance directives are in place. On [DATE] at 3:38 PM, an interview was conducted with Staff D, LPN, the Saturday Weekend Supervisor. Staff D stated they were not notified until 2:00 PM that Resident #1 had expired at 12:00 PM. Staff D stated an expectation to have been notified sooner as the supervisor so they can also notify the administration. On [DATE] at 5:35 PM, an interview was conducted with Staff E, LPN/Unit Manager. Staff E stated they were notified by Staff D via text Resident #1 had expired around 12 PM. When Staff E asked whether a Code Blue had been called, Staff D stated no. Staff E stated they then contacted Staff A, who stated Staff B had told them the resident was in cardiac arrest. Staff A told Staff E they had not called a Code Blue but had performed 15 minutes of CPR, stopped, went to get Staff B, returned, resumed CPR, and called time of death at 12:15 PM. Staff E stated Staff A did not call 911 or the physician when they stopped CPR. Staff E stated once Resident #1's guardian agreed to hospice services, they had made it abundantly clear to all care staff Resident #1 remained a full code. On [DATE] at 3:06 PM, an interview was conducted with the Director of Nursing (DON) and Nursing Home Administrator (NHA). The DON stated they were notified by text at 2:14 PM on [DATE] Resident #1 had expired. The DON stated Staff A told them they had completed CPR for 15 minutes. The DON stated during their conversation, they realized Staff A had not administered CPR in accordance with facility policy. The DON stated Staff A did not call a Code Blue and they did not know why Staff A failed to follow expected procedures. The DON stated all staff on the shift were unaware a Code Blue had occurred, and Staff A did not alert anyone or request help. The DON stated they checked the crash cart and verified it had not been opened. The DON stated they were unable to confirm whether CPR was actually performed. The DON stated the facility's process requires staff to check code status, begin compressions, call a Code Blue, and have someone call 911. The DON stated Staff A did not follow this process and they could not determine why, noting they found no system failure during their review. Record review showed Resident #1 was admitted [DATE], readmitted [DATE], and had diagnoses including dementia, diabetes, chronic kidney disease, and heart failure. A [DATE] Quarterly minimum data Set (MDS) dated [DATE] documented a brief interview for mental status (BIMS) score of 02, indicating severe cognitive impairment. The resident's Care Plan documented the resident as a full code. Orders reviewed confirmed full code status as of [DATE] with no end date. Review of Resident #1's progress notes revealed a progress note from Staff A, LPN on [DATE] at 2:54 PM stating: Resident family was in the room, said to the aid at 11:30 AM resident was unresponsive to call the nurse, went in the room check no pulse, provided CPR for 15 full mins, called the aid come in the room tried CPR again resident, still unresponsive, called death at 12:15 PM. A review of the undated facility's Advance Directives policy revealed, Advance directives are honored in accordance with state law and facility policy. Review of the facility's CPR policy dated [DATE] revealed the following: 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 CPR. If a resident experiences cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and: in accordance with the resident's advance directives; in the absence of advance directives or a DNR order. A review of the facility's Abuse, Neglect and Exploitation policy dated [DATE] revealed (continued on next page)		

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions revealed Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. 'Willful' means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Review of the facility's Nursing Job description revealed the following: Major Duties and responsibilities: Participates in end of life care as required Promotes teamwork, mutual respect, and effective communication 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 Fulfills responsibilities as assigned during implementation or activation of the facility's emergency plan.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review and staff interviews, the facility failed to ensure staff responsible for providing Cardiopulmonary Resuscitation (CPR) demonstrated the competency, knowledge, and skills necessary to perform CPR in accordance with professional standards and facility policy for one resident (#1) of two reviewed for CPR. Findings included: Review of the facility's Nursing Job description revealed the following: Major Duties and responsibilities: Participates in end-of-life care as required Promotes teamwork, mutual respect, and effective communication 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 Fulfills responsibilities as assigned during implementation or activation of the facility's emergency plan. On [DATE] at 10:56 AM, during a phone interview, Staff A, Licensed Practical Nurse (LPN) stated on [DATE], Staff B, Certified Nursing Assistant (CNA) notified them Resident #1 was not breathing. Staff A stated upon entering Resident #1's room they assessed for a pulse and, finding none, began CPR without calling Code Blue. Staff A reported stopping CPR after approximately 15 minutes to get Staff B, CNA, to act as a witness and assist with cleaning up the resident. Staff A stated they resumed CPR upon returning to the room. Staff A further stated they did not call a Code Blue because the family member made them nervous and acknowledged they did not follow facility CPR policy. On [DATE] at 11:47 AM, during a phone interview, Staff B, CNA stated they informed Staff A the resident was not breathing but did not return to the room with Staff A. Staff B stated they later encountered Staff A, who instructed them to gather washcloths to help clean Resident #1. Staff B stated they did not observe CPR being performed and were not instructed to call 911 or initiate a Code Blue. Staff B stated they had not received guidance regarding CPR, code status, or Code Blue procedures and believed only nurses could call a Code Blue. On [DATE] at 12:06 PM, Staff C, LPN stated they were not notified of the incident until later in the day and were not called to assist. Staff C reported no Code Blue announcement was made and the crash cart remained in the utility room with no equipment removed. Staff C stated an Ambu bag would have been removed during a Code Blue but was not. On [DATE] at 2:16 PM, the resident's Primary Care Provider (PCP) stated Staff A stepped outside their training, broke the facility's system, and acted independently. The PCP stated when a resident is full code, the process included checking code status, initiating CPR, calling 911, and continuing compressions until EMS arrives. The PCP stated they believed staff were trained and did not know why the system was not followed. The PCP stated Staff A did not appear to have participated in many required steps and reiterated the expectation to follow standard of care when advance directives are in place. The PCP stated it was their expectation CPR be initiated, emergency services contacted, and compressions continued until EMS arrival for any full code resident. On [DATE] at 3:06 PM, the Director of Nursing (DON) stated they were notified via text on [DATE] at 2:14 PM Resident #1 had expired. The DON stated Staff A reported performing CPR for 15 minutes. The DON stated Staff A did not call a Code Blue and no staff were aware CPR was being performed. The DON reported the crash cart had not been accessed and they could not verify CPR had occurred. The DON stated facility process requires checking code status, beginning CPR, calling a Code Blue, and ensuring 911 is called. On [DATE] at 5:35 PM, Staff E, LPN/Unit Manager stated Staff A reported performing CPR for 15 minutes, ceasing CPR, leaving the room to get Staff B, then returning to resume CPR. Staff E stated Staff A did not call a Code Blue, did not call 911, and did not contact the physician. Staff E stated staff had been informed the resident remained a full code despite hospice involvement. Record review showed Resident #1 was admitted [DATE], readmitted [DATE], and had diagnoses including dementia, diabetes, chronic kidney disease, and heart failure. A [DATE] Quarterly minimum [NAME] Set (MDS) dated [DATE] documented a brief interview for mental status (BIMS) score of 02, indicating severe cognitive impairment. The resident's Care Plan documented the resident (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as a full code. Orders reviewed confirmed full code status as of [DATE] with no end date. Review of a [DATE] at 2:54 PM progress note by Staff A, LPN documented: Resident family was in the room, said to the aid at 11:30 AM resident was unresponsive to call the nurse, went in the room check no pulse, provided CPR for 15 full mins, called the aid come in the room tried CPR again resident, still unresponsive, called death at 12:15 PM. Review of Staff A's education transcripts revealed no CPR training completed. Review of facility CPR policy dated [DATE], stated staff will provide basic life support, including CPR, for residents experiencing cardiac arrest in accordance with advance directives. Review of the facility's Abuse, Neglect, and Exploitation Policy dated [DATE], defined neglect as failure to provide goods and services necessary to avoid physical harm. The facility did not provide a competency policy.		