STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105558	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at West Palm Beach	5065 Wallis Road West Palm Beach, FL 33415

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 record review and interview, the facility neglected to honor a resident's full code status and failed to perform emergency care/cardio-pulmonary resuscitation (CPR) on 1 of 3 residents reviewed for advanced directives (Resident #1). The facility did not perform basic life support according to the physician's orders and advanced directives and the resident died. The staff neglected to inform administration of the incident. The Immediate Jeopardy began on [DATE] at 11:15 PM. The Immediate Jeopardy was removed effective [DATE]. The facility self-identified the serious incident as noncompliance that was Immediate Jeopardy and took immediate actions to remove the Immediate Jeopardy on [DATE]. The facility continued to implement corrective actions until they achieved substantial compliance for F600. During the survey, the facility provided to the surveyor a corrective action plan. The surveyor verified the facility's corrective actions to correct the noncompliance for F600 on [DATE], prior to the survey visit.F600 was determined to be past noncompliance as of [DATE]. The findings include:Facility policy on Abuse and Neglect, effective date [DATE], included each resident be afforded basic human rights, including the right to be free from abuse and neglect. The facility established policies and procedures to protect these rights. Employees are charged with a continuing obligation to treat residents so they are free from abuse and neglect. No employee may at any time commit an act of abuse or neglect against any resident. The policy defined neglect as the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. It also included failure to report observed or suspected abuse or neglect to the proper authorities as an example of neglect. Record review revealed Resident #1 was admitted to the facility on [DATE], a comprehensive assessment dated [DATE] documented the resident was cognitively intact and required substantial/max assist with activities of daily living, had a tracheostomy (tube in the throat to breath), and a feeding tube. The assessment further documented the resident was receiving hospice services. A review of Resident #1's care plan revealed a care plan dated [DATE] for an advanced directive of full code. A review of Resident #1's orders revealed an order dated [DATE] for a full code. Resident #1 was admitted to hospice on [DATE]. An interview was conducted with the Hospice nurse on [DATE] at 4:00 PM. She stated the resident was alert and oriented and was the one that made the determination that he wanted to be a full code. Some residents come on as full code and some do not. We honor the right to be a full code. A progress note by Staff A, dated [DATE] at 12:36 AM documented Resident #1 was found with no chest rising and no vital signs. Hospice was called and report was given. A hospice nurse was dispatched to the facility for further assistance. Post mortem care provided. An interview was conducted with the Regional Nurse Consultant (RNC) on [DATE] at 11:00 AM. The RNC stated she was conducting chart audits on [DATE] on discharged residents when she discovered there was an issue with no CPR performed on a resident that was a full code. The RNC stated she immediately notified the Administrator and it was reported to the required agencies. An interview was conducted with the Nursing Home Administrator (NHA) on [DATE] at 11:30 AM. The NHA, who is also the Abuse Coordinator, stated he was notified by the RNC that Resident #1 did not receive emergency service/CPR when he was found without a pulse. (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	The NHA stated he called Staff A, a Registered Nurse, who worked the 7P-7A shift on [DATE], who had already left the facility. The NHA stated he got a statement from Staff A by text confirming CPR and 911 was not initiated on Resident #1. The NHA stated Staff A was suspended pending investigation, and had since been terminated and reported to the board of nursing. An interview was conducted with Staff B, a Certified Nurse Assistant (CNA) on [DATE] at 10:00 AM. Staff B stated she worked 11P-7A on [DATE]. Staff B stated when she rounded at the start of her shift, she found Resident #1 unresponsive and immediately notified Staff A. Staff B stated she continued with her rounds. An interview was conducted with Staff C, a Registered Nurse on [DATE] at 11:00 AM. Staff C stated he worked 7P-7A on [DATE]. Staff C stated he had returned from break around 12:30 AM and saw the hospice chaplain at the nursing station. Staff C stated he saw Staff A charting at the nursing station and he inquired what was happening. Staff C stated Staff A told him that Resident #1 had died. Staff C stated he saw that Resident #1 was a full code on the computer screen that Staff A was on. Staff C stated he told Staff A that the resident was a full code. Staff C stated he then returned to his assignment. Staff C stated he did not tell anyone of the situation, continued his shift and left the facility. Staff C stated he has since been educated on reporting occurrences of neglect related to failure to perform basic life support according to orders to administration, on abuse/neglect, and CPR. An interview was conducted with Staff A on [DATE] at 9:00 AM. Staff A stated she worked 7P-7A on [DATE] and was responsible for Resident #1. Staff A stated Staff B notified her that Resident #1 was unresponsive on [DATE] at approximately 11:15 PM. Staff A stated she went to check on the resident and the resident was not breathing and had no vital signs. Staff A stated she did not check the resident's chart for code status. Staff A stated she assumed the resident was a Do Not resuscitate (DNR) because the resident was on hospice. Staff A stated she called the physician who told her to call hospice. Staff A stated she called hospice. Staff A stated Staff C informed her that Resident #1 was a full code over an hour after the resident had died. Staff A stated she did not tell anyone. Staff A stated she was suspended pending investigation and had not heard from the facility since the event. Staff A stated she was educated on CPR, abuse/neglect, and reporting occurrences of neglect related to failure to perform basic life support according to orders to administration. The facility's Immediate Jeopardy Removal Plan was verified as completed by the surveyor included: Criteria 1On [DATE] the Registered nurse involved with the resident received individualized training regarding Florida Cardiopulmonary Resuscitation Policy with emphasis on steps to take when a resident is unresponsive.On [DATE] the Registered nurse involved was suspended pending investigation.On [DATE] the Registered nurse's employment was terminated.25 of 25 current licensed nurses have active BLS certified CPR card.As of [DATE] 25 of 25 licensed nurses had completed a code blue drill, education, and post test. Criteria 2On [DATE] an audit of Advanced Directive Discussion forms was completed to ensure resident code status honored their wishes.On [DATE] an Ad hoc Quality Assurance Performance Improvement (QAPI) Committee meeting was held to review the recommendations made from the root cause analysis. The following team members were in attendance: Medical Director (via telephone), Executive Director, Director of Nursing, MDS Coordinator, Human Resource Coordinator, Central Supply, Business Office Manager, Activities Director, and Director of Rehab Services.The Ad hoc QAPI committee approved the recommendations.On [DATE], a Performance Improvement Plan was developed and initiated based upon Root Cause Analysis (RCA) as determined by Quality Assurance Performance Improvement committee (QAPI). RCA identified as failure to follow the Advanced Directive Policy and Procedure. Criteria 3Code Drills were initiated on [DATE] and continued until current nursing staff have participated. As of [DATE], 25 of 25 licensed nurses have participated in a drill. Education was provided to the second nurse who found the code status regarding the importance of reporting the incident to facility administration.On [DATE] licensed nurses' education was initiated. As of [DATE] 25 of 25 licensed facility nurses, received education to include CPR Policy / Procedure, Advanced Directives Policy / Procedure, Abuse/Neglect and the requirement to report to administration when (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	staff observe Neglect occurring.Education accompanied by post testing and participation in code blue drills to validate understanding and competency. All nurses obtained a passing score. As of [DATE], 111 of 111 employees have been educated on Abuse/Neglect policy and procedure that includes reporting requirements. Current staff included: Therapy, Housekeeping, Laundry, Dietary, CNAs, Nurses, Department Heads. Criteria 4 After review of the results of the drills, post test and education we had removed the Immediate Jeopardy as of [DATE]. The facility's Corrective Action Plan was verified as completed by the surveyor included: On [DATE] the Licensed nurses received training regarding Abuse and Neglect, with particular focus on performing CPR for a Full-Code patient, and reporting incidents to facility administration.Florida Cardiopulmonary Resuscitation Policy with emphasis on steps to take when a resident is unresponsive.On [DATE] the Registered nurse involved was suspended pending investigation.On [DATE] the Registered nurse's employment was terminated.25 of 25 current licensed nurses have active BLS certified CPR card.As of [DATE], 25 of 25 licensed nurses had completed a code blue drill, education, and post test.Quality Review audits will be conducted by Social Services/Designee for all new and readmitted patients using the Advanced Directive audit sheet, 5X/week for 4 weeks, then weekly for 4 weeks, then monthly for 1 month. A random audit will be conducted quarterly in line with the MDS schedule. The audits is to ensure appropriate code status is identified and carried out.All newly hired licensed nurses will be educated regarding Abuse and Neglect, and on the importance of checking all patient's code status when responding to a change in condition; including and especially for all Hospice patients.On [DATE] an Ad hoc Quality Assurance Performance (QAPI) Committee meeting was held to review the recommendations made from the root cause analysis. The following team members were in attendance: Medical Director (via telephone), Executive Director, Director of Nursing, MDS Coordinator, Human Resource Coordinator, Central Supply, Business Office Manager, Activities Director, and Director of Rehab Services.The Ad hoc QAPI committee approved the recommendations.On [DATE], a Performance Improvement Plan was developed and initiated based upon Root Cause Analysis (RCA) as determined by Quality Assurance Performance Improvement committee (QAPI). RCA identified as failure to follow the Advanced Directive Policy and Procedure.An Ad Hoc QAPI committee meeting was held at 9:30 AM on [DATE] to discuss the Performance Improvement Plan initiated by the committee on [DATE]. The findings of the review indicated all items completed on [DATE]. The following team members were in attendance: Medical Director (via telephone), Executive Director, Director of Nursing, MDS Coordinator, Human Resource Coordinator, Central Supply, Business Office Manager, Activities Director, and Director of Rehab Services. After review of the results of the drills, post test and education we have reached compliance as of [DATE]. We will continue Code Blue Drills weekly each shift x4 weeks, then monthly thereafter. Results will be reviewed in the monthly QAPI meetings to determine need for further drills and/or education. The Human Resources Generalist will monitor licensed nurses' CPR cards to ensure active CPR certification, and will check for the same for all newly hired licensed nurses as well.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 and interview, the facility failed to honor a resident's full code status and failed to perform emergency care/cardio-pulmonary resuscitation (CPR) on 1 of 3 resident's reviewed for advanced directives (Resident #1). The facility did not perform basic life support according to the physician's orders and advanced directives and the resident died. The Immediate Jeopardy began on [DATE] at 11:15 PM. The Immediate Jeopardy was removed effective [DATE]. The facility self-identified the serious incident as noncompliance that was Immediate Jeopardy and took immediate actions to remove the Immediate Jeopardy on [DATE]. The facility continued to implement corrective actions until they achieved substantial compliance for F678. During the survey, the facility provided to the surveyor a corrective action plan. The surveyor verified the facility's corrective actions to correct the noncompliance for F678 on [DATE], prior to the survey visit.F678 was determined to be past noncompliance as of [DATE]. The findings included:Facility policy on Cardiopulmonary Resuscitation (CPR), effective date, [DATE], included CPR will be provided to all residents who are identified to be in cardiac arrest unless such resident has a fully executed Do Not Resuscitate (DNR) order. In the event of cardiac arrest, immediately call for assistance. Two nurses are to verify resident identification, and fully executed DNR order located in the advanced directive section of the medical record. In the absence of a fully executed DNR order, the nurse will immediately begin CPR and will continue performing CPR until Emergency Medical Services assume responsibility. Record review revealed Resident #1 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident was cognitively intact and required substantial/max assist with activities of daily living, had a tracheostomy (tube in the throat to breath), and a feeding tube. The assessment further documented the resident was receiving hospice services.A review of Resident #1's care plan revealed a care plan dated [DATE] for an advanced directive of full code.A review of Resident #1's orders revealed an order dated [DATE] for a full code.Resident #1 was admitted to hospice on [DATE]. An interview was conducted with the Hospice nurse on [DATE] at 4:00 PM. She stated the resident was alert and oriented and was the one that made the determination that he wanted to be a full code. Some residents come on as full code and some do not. We honor the right to be a full code. A progress note by Staff A, Registered Nurse, dated [DATE] at 12:36 AM documented Resident #1 was found with no chest rising and no vital signs. Hospice was called and report was given. A hospice nurse was dispatched to the facility for further assistance. Post mortem care provided.An interview was conducted with the Regional Nurse Consultant (RNC) on [DATE] at 11:00 AM. The RNC stated she was conducting chart audits on [DATE] on discharged residents when she discovered there was an issue with no CPR performed on a resident that was a full code. The RNC stated she immediately notified the Administrator and it was reported to the required agencies.An interview was conducted with the Nursing Home Administrator (NHA) on [DATE] at 11:30 AM. The NHA stated he was notified by the RNC that Resident #1 did not receive emergency service/CPR when he was found without a pulse. The NHA stated he called Staff A, a Registered Nurse, who worked the 7P-7A shift on [DATE], who had already left the facility. The NHA stated he received a statement from Staff A by text confirming CPR and 911 was not initiated on Resident #1. The NHA stated Staff A was suspended pending investigation, and had since been terminated and reported to the board of nursing. An interview was conducted with the interim Director of Nursing (DON) on [DATE] at 11:00 AM regarding the expectations of the licensed nurses to perform basic life support including CPR and she stated she would expect the licensed nurses to follow the facility policy and perform CPR if there is no DNR orders. An interview was conducted with Staff B, a Certified Nurse Assistant (CNA) on [DATE] at 10:00 AM. Staff B stated she worked 11P-7A on [DATE]. Staff B stated when she rounded at the start of her shift, she found Resident #1 (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	unresponsive and immediately notified Staff A. Staff B stated she continued with her rounds. An interview was conducted with Staff C, a Registered Nurse on [DATE] at 11:00 AM. Staff C stated he worked 7P-7A on [DATE]. Staff C stated he had returned from break around 12:30 AM and saw the hospice chaplain at the nursing station. Staff C stated he saw Staff A charting at the nursing station and he inquired what was happening. Staff C stated Staff A told him that Resident #1 had died. Staff C stated he saw that Resident #1 was a full code on the computer screen that Staff A was on. Staff C stated he told Staff A that the resident was a full code. Staff C stated he then returned to his assignment. Staff C stated he did not tell anyone of the situation, continued his shift and left the facility. Staff C stated he has since been educated on CPR. An interview was conducted with Staff A on [DATE] at 9:00 AM. Staff A stated she worked 7P-7A on [DATE] and was responsible for Resident #1. Staff A stated Staff B notified her that Resident #1 was unresponsive on [DATE] at approximately 11:15 PM. Staff A stated she went to check on the resident and the resident was not breathing and had no vital signs. Staff A stated she did not check the resident's chart for code status. Staff A stated she assumed the resident was a Do Not resuscitate (DNR) because the resident was on hospice. Staff A stated she called the physician who told her to call hospice. Staff A stated she called hospice. Staff A stated Staff C informed her that Resident #1 was a full code over an hour after the resident had died. Staff A stated she did not tell anyone. Staff A stated she was suspended pending investigation and had not heard from the facility since the event. Staff A stated she was educated on CPR. The facility's Immediate Jeopardy Removal Plan was verified as having been completed by the surveyor included:Criteria 1On [DATE] the Registered nurse involved with the resident received individualized training regarding Florida Cardiopulmonary Resuscitation Policy with emphasis on steps to take when a resident is unresponsive.On [DATE] the Registered nurse involved was suspended pending investigation.On [DATE] the Registered nurse's employment was terminated.25 of 25 current licensed nurses have active BLS certified CPR card.As of [DATE] 25 of 25 licensed nurses had completed a code blue drill, education, and post test.Criteria 2On [DATE] an audit of Advanced Directive Discussion forms was completed to ensure resident code status honored their wishes.On [DATE] an Ad hoc Quality Assurance Performance Improvement (QAPI) Committee meeting was held to review the recommendations made from the root cause analysis. The following team members were in attendance: Medical Director (via telephone), Executive Director, Director of Nursing, MDS Coordinator, Human Resource Coordinator, Central Supply, Business Office Manager, Activities Director, and Director of Rehab Services.The Ad hoc QAPI committee approved the recommendations.On [DATE], a Performance Improvement Plan was developed and initiated based upon Root Cause Analysis (RCA) as determined by Quality Assurance Performance Improvement committee (QAPI). RCA identified as failure to follow the Advanced Directive Policy and Procedure.Criteria 3Code Drills were initiated on [DATE] and continued until current nursing staff have participated. As of [DATE] , 25 of 25 licensed nurses have participated in a drill. Education was provided to the the second nurse who found the code status regarding the importance of reporting the incident to facility administration.On [DATE] licensed nurses' education was initiated. As of [DATE], 25 of 25 licensed facility nurses, received education to include CPR Policy / Procedure, Advanced Directives Policy / Procedure, Abuse/Neglect. Education accompanied by post testing and participation in code blue drills to validate understanding and competency. All nurses obtained a passing score. Criteria 4 After review of the results of the drills, post test and education we have removed the Immediate Jeopardy as of [DATE]. The facility's Corrective Action Plan was verified as having been completed by the surveyor included:On [DATE] the Registered nurse involved with the resident received individualized training regarding Florida Cardiopulmonary Resuscitation Policy with emphasis on steps to take when a resident is unresponsive.On [DATE] the Registered nurse involved was suspended pending investigation.On [DATE] the Registered nurse's employment was terminated.25 of 25 current licensed nurses have active BLS certified CPR card.As of [DATE] 25 of 25 licensed nurses had completed a code blue drill, education, and post test. On [DATE] an Ad hoc (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Quality Assurance Performance Improvement (QAPI) Committee meeting was held to review the recommendations made from the root cause analysis. The following team members were in attendance: Medical Director (via telephone), Executive Director, Director of Nursing, MDS Coordinator, Human Resource Coordinator, Central Supply, Business Office Manager, Activities Director, and Director of Rehab Services.The Ad hoc QAPI committee approved the recommendations.On [DATE], a Performance Improvement Plan was developed and initiated based upon Root Cause Analysis (RCA) as determined by Quality Assurance Performance Improvement committee (QAPI). RCA identified as failure to follow the Advanced Directive Policy and Procedure.An Ad Hoc QAPI committee meeting was held at 9:30 AM on [DATE] to discuss the Performance Improvement Plan initiated by the committee on [DATE]. The findings of the review indicated all items completed on [DATE]. The following team members were in attendance: Medical Director (via telephone), Executive Director, Director of Nursing, MDS Coordinator, Human Resource Coordinator, Central Supply, Business Office Manager, Activities Director, and Director of Rehab Services. After review of the results of the drills, post test and education we have reached compliance as of [DATE]. We will continue Code Blue Drills weekly each shift x4 weeks, then monthly thereafter. Results will be reviewed in the monthly QAPI meetings to determine need for further drills and/or education. The Human Resources Generalist will monitor licensed nurses' CPR cards to ensure active CPR certification, and will check for the same for all newly hired licensed nurses as well.