STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105718	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Central Park	702 S Kings Ave Brandon, FL 33511

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure baseline care plans for code status were in place for three residents (#1, #2, and #3) of three residents sampled. Resident #1 was readmitted on [DATE] with diagnoses to include but not limited to chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), diabetes mellitus, morbid obesity, altered mental status, generalized muscle weakness, dysphagia, obstructive sleep apnea, stage III chronic kidney disease, hypertension, anemia, sepsis, pneumonia, metabolic encephalopathy, congestive heart failure (CHF), and dependence on supplemental oxygen.Review of Resident #1's physician order dated 9/8/25 showed resident was a full code. Review of Resident #1's Care Plan revealed no care plan for a code status. Resident #2 was admitted on [DATE] with diagnoses to include but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery, COPD, CHF, atrial fibrillation, and pulmonary embolism. Review of Resident #2's physician order dated 9/11/25 showed resident was a full code. Review of Resident #2's Care Plan revealed no care plan for a code status until 10/3/25.Resident #3 was admitted on [DATE] with diagnoses to include but not limited to COPD, atrial fibrillation, CHF, pulmonary hypertension, non-ST elevation myocardial infarction, and stage 3 chronic kidney disease. Review of Resident #3's admitting physician order dated 9/13/25 showed resident was a do not resuscitate (DNR). Review of Resident #3's Care Plan revealed no care plan for a code status until 9/17/25.During an interview on 10/8/25 at 1:31 PM the Social Service Director (SSD) stated upon admission code status is reviewed with each resident and resident representative (RR). The SSD stated the nurse goes over this with the resident at the time of admission and social services reviews again within 72 hours. The SSD stated the code status is important and it should be on the care plan. The SSD confirmed Resident #1, #2, and #3 did not have baseline care plans in place. During an interview on 10/8/25 at 2:02 PM the Assistant Director of Nursing (ADON) stated the admitting nurse reviews resident and RR preference for code status and should then place the code status on the baseline care plan. Once the comprehensive care plan is started the minimum data set (MDS) nurse would place the code status in the comprehensive care plan. The code status is important due to ensuring resident's wishes are followed. During an interview on 10/8/25 at 2:25 PM the Nursing Home Administrator (NHA) stated the expectation was for baseline care plans to be put in place within 48 hours for code status.Review of facility's policy titled Plans of Care, dated 9/25/2017 revealed Policy: An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representatives(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. Plan of care is to be maintained as part of the final medical record. Procedure: . develop and implement an Individualized Person-Centered baseline plan of care within 48 hours of admission that includes, but not limited to, initial goals based on the admission orders, physician orders, dietary orders, therapy services, social services, PASARR recommendations, if applicable, and other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs are met appropriately until the Comprehensive plan of care is completed.

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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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure nursing staff had the skills, knowledge and certification necessary to provide cardiopulmonary resuscitation (CPR) services for one resident (#1) of three residents sampled.Review of Resident #1's admission record revealed a readmission date of [DATE] with diagnoses to include but not limited to chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), diabetes mellitus, morbid obesity, altered mental status, generalized muscle weakness, dysphagia, obstructive sleep apnea, stage III chronic kidney disease, hypertension, anemia, sepsis, pneumonia, metabolic encephalopathy, congestive heart failure (CHF), and dependence on supplemental oxygen. Review of Resident #1's physician order dated [DATE] showed the resident was a full code. Review of Resident #1's Care Plan revealed no care plan for a code status. Review of Resident #1's medical record revealed a note dated [DATE] at 8:25 a.m. authored by Staff A, Licensed Practical Nurse (LPN) titled: SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers: Unresponsiveness . Full Code; . At 2026 EST [eastern standard time] I was called to room [ROOM NUMBER]A. Upon arrival the pt [patient] was found unresponsive, pulse-less, and apneic. Code blue activated immediately. CPR [cardiopulmonary resuscitation] was initiated per ACLS [advanced cardiac life support] protocol. Code team arrived at bedside and resuscitation measures began. During code, pt achieved return of spontaneous circulation (ROSC) with thready pulse at 133 BPM [beats per minute] and blood pressure of 151/54 mmHg [millimeters of mercury] at 2033. At 2043 EMS [emergency medical service] arrived at bedside shortly thereafter. Repeat blood pressure 150/51 pulse 152. Pt stabilized for transport. During an interview on [DATE] at 2:03 p.m. Staff B, CNA stated during normal rounds finding Resident #1 unresponsive. Staff B, CNA stated immediately calling for Staff A, LPN. Staff A, LPN came into Resident #1's room. Staff A, LPN checked Resident #1's pulse and said it was low and told me to get another nurse. When returning Staff C, LPN, Staff F, CNA and Staff H, CNA were performing CPR. Staff A, LPN was standing between the dressers in the room. I was not needed in the room, so I went to open the door for EMS when they arrived. Staff B, CNA stated not being certified in CPR. During an interview on [DATE] at 9:31 a.m. Staff C, LPN stated hearing assistance was needed downstairs in Resident #1's room. Staff C, LPN explained being familiar with Resident #1 as having cared for the resident, the prior evening and knew resident was a full code. Staff C, LPN explained no other staff members were in the room upon entering. Staff F, CNA and Staff H, CNA entered at almost the same time as me. Staff C, LPN stated immediately checking Resident #1's pulse, resident did not have one. Resident #1 had oxygen on via nasal canal. Staff C said, Immediately, I dropped the head of the bed and started CPR. I became tired and requested to switch. Staff F, CNA took over compressions. I then placed Resident #1's CPAP (Continuous Positive Airway Pressure) on Resident #1. Staff E, RN (Registered Nurse) brought the backboard in, we checked resident #1's pulse and placed the backboard. Staff D, LPN entered, and I asked her to call 911. Staff F, CNA requested to switch at this time. Staff H, CNA jumped in and took over compressions. Staff H, CNA requested to switch and Staff F, CNA continued with the compressions. EMS arrived and took over. Staff C, LPN confirmed being certified in CPR. During an interview on [DATE] at 10:25 a.m. Staff F, CNA stated a code blue was called and headed to Resident #1's room. Staff H, CNA and I were just steps behind Staff C, LPN and entered the room. No other staff members were in the room when we all entered. Staff C, LPN immediately checked Resident #1's pulse and said there was not one. Staff C, LPN dropped the head of the bed, and decided resident was too heavy to move to the floor, then Staff C, LPN started CPR. Staff C, LPN got tired at about the same time the back board arrived, Staff H, CNA and I placed the board. Staff C, LPN checked for a pulse and then I jumped in and continued started compressions. Staff F said, I requested to switch. Staff C, LPN checked for a pulse, then Staff H, CNA started compressions. Another female was in the room and was going to switch with Staff H, CNA but just froze up (stood there). I therefore jumped back in and continued with compressions. Staff F, CNA stated not remembering who the female who froze up was as being new to the facility. EMS arrived and took over care of the resident. Staff F, CNA confirmed being certified in CPR. During an interview on [DATE] at 10:37 a.m. Staff A, LPN stated Staff B, CNA, yelled to come to Resident #1's room. Staff A said, I immediately went to the room, noted Resident #1 not responding. I ran out of the room to get the blood pressure machine, called a rapid response, and verified code status. Staff A, LPN stated taking the crash cart back to Resident #1's room. Staff H, CNA was providing compressions when I arrived back to Resident